

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
EASTERN DIVISION

~~~~~  
STACIE RAY, BASIL ARGENTO, JANE DOE,  
AND ASHLEY BREDAS,  
Plaintiffs,

vs. Civil Action No.  
2:18-CV-00272-MHW-CMV

AMY ACTON, IN HER OFFICIAL CAPACITY  
AS DIRECTOR OF THE OHIO DEPARTMENT  
OF HEALTH, et al.,

Defendants.

~~~~~  
Deposition of
RYAN GORTON, M.D.

October 8, 2019

10:15 a.m.

Taken at:

Calfee Halter & Griswold, LLP
41 South High Street, Suite 1200
Columbus, Ohio

Kimberly A. Kaz, RPR, Notary Public

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1 RYAN GORTON, M.D., of lawful age,
2 called for examination, as provided by the
3 Federal Rules of Civil Procedure, being by me
4 first duly sworn, as hereinafter certified,
5 deposed and said as follows:

6 EXAMINATION OF RYAN GORTON, M.D.

7 BY MR. BLAKE:

8 Q. Please state and spell your name
9 for the record.

10 A. Ryan Nicholas Gorton. It's R-y-a-n
11 N-i-c-h-o-l-a-s G-o-r-t-o-n.

12 Q. And are you here to testify
13 regarding an expert opinion that you rendered
14 in the case of Stacie Ray, et al., versus the
15 Director of the Ohio Department of Health,
16 et al.?

17 A. I am.

18 Q. What are the areas of expertise in
19 which you are qualified to give expert
20 testimony?

21 A. Transgender health care.

22 Q. Is that all?

23 A. I'm also an emergency medicine
24 physician, but I don't think this case has to
25 do with that, so...

1 Q. So you -- you feel as if you're
2 qualified as an expert in two areas,
3 transgender health care and emergency medicine,
4 but that as it relates to this case, only the
5 transgender health care part is relevant; is
6 that accurate?

7 A. Yes.

8 Q. By "transgender health care," what
9 do you mean?

10 A. The health care specific to
11 transgender patients, which is usually divided
12 into medical care, mental health care and
13 surgical care as well as the primary care
14 services that they need that are unrelated to
15 that.

16 Q. Okay. I assume you've been deposed
17 a number of times, so I'm not going to spend a
18 bunch of time going through sort of ground
19 rules. You seem like you know how to take a
20 deposition. I will just say that, you know, if
21 at any time you need a break, as long as
22 there's not a question pending, just let me
23 know, and we'll take a break.

24 Also, if you don't understand a
25 question, you know, you can let me know. If

1 you answer a question, I'll assume you
2 understood the question; is that fair?

3 A. Yes.

4 Q. Okay. Can you start with just
5 describing briefly your -- your education and
6 undergraduate?

7 A. I got a Bachelor of Science in
8 biochemistry from North Carolina State
9 University, and then I got my medical degree
10 from the University of North Carolina Chapel
11 Hill School of Medicine.

12 Q. And after obtaining your medical
13 degree from Chapel Hill, did you enter a
14 residency program?

15 A. I did.

16 Q. And where did you conduct your
17 residency?

18 A. Brooklyn, New York at Kings County
19 Hospital.

20 Q. And was that a general residency
21 or, like, a specialty or --

22 A. It was emergency medicine.

23 Q. And how long was that residency?

24 A. Four years.

25 Q. And what is emergency medicine?

1 A. The saying goes any person, any
2 problem, any time. So the provision of,
3 essentially, all emergency care that people
4 might present to a hospital with.

5 Q. So is this, like, the emergency
6 room doctor when you walk in the emergency
7 room, you're going to be seen by a physician at
8 some point? Is that what -- is that what you
9 do or what you trained as a resident to do?

10 A. Correct.

11 Q. After your residency, did you
12 immediately begin practicing somewhere, did you
13 go to a fellowship, or what did you do?

14 A. I didn't do a fellowship, I started
15 working at Saint Tammany Parish Hospital in
16 Covington, Louisiana.

17 Q. What year was that?

18 A. 2002.

19 Q. And how long were you in Covington?

20 A. About three years.

21 Q. Where did you go after that?

22 A. I moved to California and started
23 practicing at Sutter Davis Hospital in Davis,
24 California and Lyon-Martin Health Services,
25 which, at the time was Lyon-Martin Women's

1 Health Services in San Francisco.

2 Q. Is Davis, California near
3 San Francisco?

4 A. It's closer to Sacramento.

5 Q. So you would commute between the
6 two?

7 A. Yes. I live in Davis and would go
8 to San Francisco -- drive to San Francisco to
9 work at Lyon-Martin.

10 Q. And you started that in 2005?

11 A. Yes.

12 Q. Do you still work at any of those
13 places or --

14 A. I still work at both of those
15 places.

16 Q. Okay. Any other employment or --
17 yeah. Any other employment since you started
18 working at Sutter Davis and Lyon-Martin?

19 A. No.

20 Q. Other than your MD and your
21 residency in emergency medicine, have you
22 obtained any other medical certifications or
23 licenses or specialties?

24 A. I am board certified in emergency
25 medicine and I am also certified with WPATH in

1 their GEI program, which is something that I've
2 added to my resume since I provided you one
3 because I recently found out I passed the test.

4 Q. Okay. So let's talk about the
5 board certification in emergency medicine. Is
6 that -- is that a license that you're required
7 to maintain in order to practice medicine?

8 A. In order to practice medicine, no,
9 but a lot of emergency departments require that
10 to be able to be employed there.

11 Q. Are there, like, classes you have
12 to take or coursework you have to complete
13 within a year or two-year period in order to
14 maintain that certification?

15 A. You have to do a certain amount of
16 continuing medical education, and ABEM, the
17 American Board of Emergency Medicine, has this
18 program they call ConCert, which is continuous
19 certification, where you have to take a test.
20 I can't tell you the exact number, but it's --
21 I think it's, like, seven out of ten years
22 between your test -- retesting for board
23 certification, and then every tenth year, you
24 have to sit for an exam.

25 Q. And who -- who, then, approves the

1 certification for the -- for the doctors that
2 are board certified?

3 A. I'm not sure I understand the
4 question.

5 Q. Well, what organization is in
6 charge of issuing the licenses or the
7 certifications?

8 A. The board certification, like I
9 said, is ABEM, the American Board of Emergency
10 Medicine.

11 Q. Okay. That's the actual entity
12 that administers the curriculum or the
13 requirements in order to get the certification?

14 A. Correct.

15 Q. Okay. And who is -- what is ABEM
16 comprised of or who are ABEM's members?

17 A. Emergency medicine physicians in
18 the U.S.

19 Q. What does it take to be -- well,
20 does ABEM have, like, a board or panel? I
21 mean, who sets the criteria?

22 A. I am honestly not certain of how
23 they set the criteria, but they set the
24 criteria for what is an emergency medicine
25 residency and what it must contain, and they

1 also set the criteria that you have to have
2 completed emergency medicine residency before
3 you sit for the boards, but I don't know how
4 they decide what questions are on the exam or,
5 like, specifics like that.

6 Q. But it's -- in any event, it's
7 other doctors who are -- this certification and
8 who have received training as emergency
9 medicine physicians, right?

10 A. Sure.

11 Q. Okay. What is the WPATH GEI
12 program?

13 A. WPATH is the World Professional
14 Association for Transgender Health, which is
15 essentially the professional organization for,
16 generally, medical and mental health providers
17 who provide care for transgender patients. And
18 "GEI" stands for Global Education Initiative.
19 And it's not like a board certification, but it
20 is similar in that you have to have certain
21 qualifications and a certain set of classes
22 that you have to complete and then you sit for
23 an exam. And so it's an indication that WPATH
24 thinks you have at least basic competency in
25 providing transgender care.

1 Q. Who sets the coursework or exams or
2 who creates the exams for the GEI program?

3 A. Medical and mental health providers
4 within WPATH. And I should add that I was
5 actually allowed to grandfather in because of
6 extensive experience since this is a relatively
7 new program, so because of that, I was allowed
8 just to sit for the exam, although I did
9 actually sit in on the first course that they
10 require for people who don't have an extensive
11 amount of experience to become certified.

12 Q. But you weren't required to take
13 the full coursework before sitting for the
14 exam, right?

15 A. No, because of previous experience.
16 And that's pretty typical for most of these
17 things. Like, the American Board of Emergency
18 Medicine originally allowed physicians who
19 hadn't completed a residency but had extensive
20 experience in emergency medicine just to sit
21 for the exam.

22 Q. And you said you just recently
23 received word that you passed the GEI exam,
24 right?

25 A. Yes.

1 Q. And when did you sit for that exam?

2 A. There was a period of time you
3 could do it, and I think I did it almost near
4 the end of that, and I think it was -- it was
5 sometime in September because I remember doing
6 it at the USPATH conference.

7 Q. So they offered the exam only
8 certain times during the year?

9 A. There was a window during which you
10 could take the exam. I don't know specific
11 times that --

12 Q. What was that window?

13 A. It was at least a few weeks, but it
14 might have been longer than that. I kind of
15 just wrote the deadline down in my schedule and
16 took it before the deadline.

17 Q. And that was, you think, in
18 September?

19 A. I know it was in September. I
20 couldn't tell you the exact date.

21 Q. This year?

22 A. This year, yes.

23 Q. Where did you go to take the exam?

24 A. It's an online exam, so I did it,
25 actually, in my hotel room.

1 Q. So you took the exam from your
2 hotel room while you were attending a WPATH
3 conference or something?

4 A. USPATH.

5 Q. USPATH.
6 How long did the exam take you to
7 complete?

8 A. Probably four hours total, but I
9 broke it up.

10 Q. Do you recall approximately how
11 many questions are on it?

12 A. I don't recall the exact number,
13 but I would say it's probably somewhere between
14 20 and 60.

15 Q. What about your exam for board
16 certification in emergency medicine, how --
17 where did you take that exam?

18 A. The initial -- or the first time
19 when you get board certified, there are
20 actually two exams. There's a written one, and
21 I took that somewhere in Texas, maybe
22 Dallas/Fort Worth.

23 Q. You had to go someplace where they
24 were offering the exam?

25 A. Yes. And then I took the oral

1 exam. It was somewhere in the midwest, maybe
2 Chicago. I'm not sure.

3 Q. Did you go somewhere else to meet
4 with folks and be examined orally?

5 A. Exactly, for the oral exam. And
6 then my one recertification, I just did at the
7 testing center in California.

8 Q. Again, some other place where they
9 say here's a location you can go to recertify,
10 right?

11 A. It used to be they would have,
12 essentially, a pencil-and-paper exam that
13 everybody took and they -- there were a few
14 places in the U.S. at certain times you could
15 take it, but now it's an electronic exam, so
16 you just find the closest testing center to
17 you, and that's both for people initially
18 certifying now for the written exam and for
19 anybody who's recertifying.

20 Q. Okay. So the process now, if you
21 were to be coming out of med school at this
22 point, you would take the written exam at one
23 of these testing locations, remote testing
24 locations around the country, and then you'd
25 still have to go for your oral exam somewhere,

1 right?

2 A. Correct.

3 Q. Is it always in the midwest, or
4 that's just when it was there?

5 A. I have no idea.

6 Q. Okay. Do you recall how many
7 questions were on the written exam?

8 A. Not even close. No idea.

9 Q. I mean, is it, like, 100, 200?

10 A. It took me a couple of hours to
11 complete the recertification exam, so maybe a
12 hundred. That's a total guess, though. It
13 wasn't short, but it wasn't a two-day exam.

14 Q. How long did you spend preparing
15 for the ABME [sic] exam?

16 A. ABEM. And do you mean the initial
17 certification or recertification?

18 Q. The initial certification.

19 A. Honestly, not that much 'cause I
20 was fresh out of residency. Maybe ten, 20
21 hours.

22 Q. And how long did you spend
23 preparing for the GEI exam?

24 A. Maybe a couple of hours, which was
25 mostly just reviewing the WPATH standard of

1 care.

2 Q. All right. You mentioned that you
3 didn't have to take any coursework prior to
4 sitting for the GEI program, and that was based
5 on your experience with transgender medicine;
6 is that right?

7 A. Correct.

8 Q. So can you briefly describe what
9 that experience has been since seems like about
10 2005?

11 A. I've been continuously working at
12 Lyon-Martin with a moderately large panel of
13 trans patients, but then, also, I teach
14 students and residents, I do presentations, I
15 work on the -- on TransLine, the national
16 clinical consultation service, and I also keep
17 up to date with the trans literature, the trans
18 medical literature.

19 Q. So do you have trans patients at
20 Lyon-Martin and Sutter Davis?

21 A. In emergency medicine, you don't
22 have patients that you follow longitudinally,
23 but, yes, I've seen a number of trans patients
24 at Sutter Davis.

25 Q. Is your work at Lyon-Martin

1 emergency medicine as well?

2 A. No. It's primary care, so I see
3 patients repeatedly over a course of time.

4 Q. Okay. So primary care, that's at
5 Lyon-Martin, and then you're still maintaining
6 your emergency medicine practice at Sutter
7 Davis; is that accurate?

8 A. Correct.

9 Q. And so you have seen trans patients
10 at Sutter Davis, but that's just because you
11 take whomever's having emergency, and some of
12 those folks happen to be trans, right?

13 A. Correct.

14 Q. But as a primary care physician at
15 Lyon-Martin, trans patients come in and you
16 treat them as their primary care physician,
17 right?

18 A. Correct.

19 Q. Okay. You said it used to be known
20 as women's health, Lyon-Martin Women's Health.
21 It's no longer called that?

22 A. Lyon-Martin was originally a for
23 us, by us clinic for lesbian and bisexual
24 women, and it was either late '70s or early
25 '80s that it was founded. And then in the

1 '90s, they started providing transgender care,
2 and somewhere around 2007 or '8 or maybe even
3 2009, the clinic changed the name from
4 Lyon-Martin Women's Health Services to
5 Lyon-Martin Health Services, recognizing that
6 we have a lot of patients who weren't women,
7 they were transgender men and transgender
8 women.

9 Q. Okay. So you provide care -- that
10 was going to be my next question. Although
11 Lyon-Martin was originally a women's health
12 clinic, when it comes to the transgendered
13 patient, you treat both transgendered men and
14 transgendered women?

15 A. Correct.

16 Q. Got it.

17 So it dropped -- at this point, has
18 dropped the "women's health" part of their
19 name?

20 A. To be more inclusive, yes.

21 Q. You say you teach students and
22 residents. Is Lyon-Martin a teaching hospital?

23 A. It's not a hospital, it's a clinic,
24 but, yes, we do have students and residents all
25 the time.

1 Q. You get them on, like, some sort of
2 rotation or something?

3 A. Yes.

4 Q. Okay. As part of their residency,
5 some of those folks come out to Lyon-Martin and
6 work?

7 A. Yes, although it's more students
8 than residents.

9 Q. Okay. And when you mean students,
10 you mean, like, medical students?

11 A. Medical students, nurse
12 practitioner students, physician's assistant
13 students.

14 Q. Okay. And at Sutter Davis, is that
15 a teaching hospital?

16 A. It has a family practice residency,
17 but that's it.

18 Q. Okay. And you're not involved in
19 that?

20 A. I am because the family practice
21 residents, as part of their residency, do do
22 rotations in the emergency department, but it's
23 an occasional thing.

24 Q. It's a very small part of what you
25 do?

1 A. Correct.

2 Q. When you were referencing your
3 experience with trans medicine and teaching
4 students and residents, you were talking about
5 what you do at Lyon-Martin, right?

6 A. Yes. But I actually do, like, once
7 a year, maybe once every two years, 'cause it's
8 a three-year residency, do talk on trans
9 medicine for the family practice residents at
10 Sutter Davis just 'cause I have that expertise
11 and they ask me to do it.

12 Q. So the Sutter Davis residents, in
13 that family practice, as part of their
14 curriculum, at some point during their stint
15 there, they ask you to come and talk to them
16 about some of these transgender issues?

17 A. Correct.

18 Q. What is TransLine?

19 A. It's a national clinical
20 consultation service that essentially provides
21 a way for health care providers to ask
22 questions of health care providers who are more
23 experienced in transgender care about their
24 patients. So if you have, say, a family
25 practice doctor in rural Iowa who's never had a

1 trans patient and they have one and they have
2 questions, they can call -- or, not call, they
3 can submit an electronic ticket, and most of
4 the time, they're answered by e-mail.
5 Occasionally, we call people and have a
6 conversation.

7 Q. Okay. So this is, like, a
8 doctor-to-doctor, medical provider-to-medical
9 provider interface for folks who don't have a
10 lot of experience with this issue to reach out
11 to individuals who have experience with
12 transgender issues, right?

13 A. Mostly. Though, occasionally, we
14 do get some very experienced providers who ask
15 very tough questions that takes a while to
16 answer. But mostly it's providers with maybe
17 not completely inexperience, but they have a
18 patient who has something they've never seen
19 before. They may have ten trans patients, but
20 this is just a complex case.

21 Q. Right. It's a resource that
22 medical providers have available to them?

23 A. Correct.

24 Q. And what's your involvement with
25 TransLine?

1 A. I'm the lead clinician and I also
2 answer questions. It's a rotation. There's a
3 number of different LGBT health care centers
4 that staff it, and so I do our portion of
5 answering questions, and then I also am a
6 resource for some of the other providers. So a
7 provider who's answering questions might not be
8 able to answer something, so it gets bounced to
9 me.

10 Q. Okay. So you're like a resource
11 for the resource sometimes; is that fair?

12 A. Sometimes. Most of the time,
13 it's -- they don't have to ask anything. And,
14 I mean, honestly, I sometimes have to seek
15 outside assistance if it's really super
16 complicated.

17 Q. From other people within the
18 TransLine network?

19 A. Yes, or occasionally consultants
20 that I know.

21 Q. Okay. What is a lead clinician,
22 what's the significance of that title?

23 A. I think one is that I'm the second
24 line if there's a question that's not readily
25 answered, but also, I work with JM Jaffe,

1 that's J-a-f-f-e, and JM is the -- I'm not sure
2 what their title is. I think it's manager, but
3 they're the one who sets the schedules and
4 sends people the tickets to answer and sort of
5 runs TransLine, and they and I go over data.
6 Actually, at USPATH, we presented one paper
7 about TransLine unitization, so some meta level
8 stuff.

9 Q. So JM Jaffe, that's sort of the
10 administrative arm of TransLine, and you do
11 some coordination with them?

12 A. Correct.

13 Q. Okay. Approximately how many times
14 have you been an expert witness in the last ten
15 years?

16 A. Well, what do you define as expert
17 witness? Like, what part of it?

18 Q. Sure. Any time that you've been
19 retained by an attorney or party to serve as an
20 expert witness, whether or not you rendered an
21 opinion or sat for a deposition or examined at
22 trial.

23 A. Gotcha. So probably eight to ten
24 times in the past ten years. It could be a
25 little more. Maybe call it eight to 12.

1 Q. What types of matters have -- have
2 you been retained in as an expert witness those
3 eight to 12 times?

4 A. They're all transgender cases. I
5 haven't been an emergency medicine expert
6 witness.

7 Q. Have you ever been a party to a
8 lawsuit?

9 A. Have I ever been sued?

10 Q. Yes.

11 A. Yes.

12 Q. Or sued, or you're a plaintiff,
13 right, you're the one --

14 A. Never been a plaintiff, but I've
15 been sued.

16 Q. And the times -- is there more than
17 once?

18 A. Yes.

19 Q. Okay. How many times?

20 A. Five, I think.

21 Q. Were those -- I'm assuming those
22 were all related to your medical practice?

23 A. Yes.

24 Q. Were those medical malpractice
25 cases?

1 A. Yes.

2 Q. You were a defendant?

3 A. Yes.

4 Q. Were any of those related to your
5 work as a provider of transgender medicine?

6 A. One.

7 Q. When was that case?

8 A. Couple of years ago.

9 Q. So that was a patient that you were
10 seeing at Lyon?

11 A. At Lyon-Martin, yes.

12 Q. What were the allegations in that
13 matter?

14 MS. INGELHART: Objection. To the
15 extent you can answer without waiving
16 privilege, you can answer.

17 THE WITNESS: So it was a patient
18 who sued the clinic and me for being referred
19 for sex reassignment surgery, though I don't
20 believe they sued the surgeon. I was dropped
21 from the case, but I believe the clinic
22 settled.

23 Q. Did the plaintiff claim that they
24 should not have been referred for sex
25 reassignment surgery?

1 A. I think there may be a
2 nondisclosure agreement, I apologize, that I'm
3 not entirely sure, but I think there was, so
4 I'm not sure how much I can actually say.

5 Q. Do you recall the name of the
6 plaintiff or the name of the case?

7 MS. INGELHART: Same objection as
8 before. You can answer.

9 THE WITNESS: Yes. I don't know if
10 it violates HIPAA to say that. I mean, I'm
11 just not sure.

12 Q. Yeah. Well, the case should be
13 public record. I mean, it was filed. It was a
14 complaint.

15 A. Okay.

16 Q. And, again, if you're under an NDA
17 which says the only thing you can say if asked
18 about this thing is I was dropped from the case
19 and I believe the hospital settled, the clinic
20 settled, so be it. But, you know, the name of
21 the -- the name of the case is public record.

22 MS. INGELHART: Objection. Unless
23 it's a Jane Doe.

24 MR. BLAKE: That's fine.

25 THE WITNESS: It wasn't a Jane Doe.

1 It was -- the last name was Page, P-a-g-e, and
2 I'm not sure what name the first name they
3 used, but it was -- "J" was the initial.

4 Q. But it would be Page versus --

5 A. Lyon-Martin and me.

6 Q. Yeah. And you said a couple years
7 ago, right?

8 A. Yeah. It feels like a couple of
9 years ago.

10 Q. Okay. So maybe filed in 2016, '17
11 or '18?

12 A. I don't think it would have been as
13 late as '18.

14 Q. Okay. So these eight to 12
15 transgendered cases that you've been an expert
16 witness is, what, generally, are the issues
17 involved?

18 A. I would say at least half are
19 transgender patients in prison who are suing to
20 get medically necessary care.

21 Q. And what is that? That's some
22 amount of, like, reassignment, either it's
23 hormone treatment or a medical intervention of
24 some other kind; is that accurate?

25 A. And social transition issues.

1 Q. Okay. Do you consider social
2 transition part of medical treatment?

3 A. Yes.

4 Q. And was the issue that the prison
5 was not providing the medically necessary
6 treatment and it was your expert testimony that
7 this is medically necessary and so it needs to
8 be provided?

9 A. Not all those cases I testified in,
10 but, yes, in the cases where I did.

11 Q. That was your opinion in the cases
12 where you testified, and had you testified,
13 that would have been your opinion?

14 A. I can't tell you what my opinion
15 would have been in the other cases because I
16 never got there, so...

17 Q. Have you ever been retained in a
18 prison case, transgendered prison case where
19 you didn't find that the treatment was
20 medically necessary?

21 A. Like I said, I didn't render an
22 opinion in a couple of those, so I can't tell
23 you what my opinion would have been, but in the
24 cases where I did render an opinion, in all
25 those, it was pretty obvious that the person

1 needed medically necessary care.

2 Q. All right. So the other half were
3 not prison cases. I assume they fall into
4 probably several categories. Can you tell me
5 what those categories are?

6 A. Sure. So this case is one of them.

7 Q. This is an identity document case?

8 A. Correct.

9 Q. Any other identity document cases
10 besides this one?

11 A. One other.

12 Q. Okay. What other types of cases?

13 A. There was one case where I -- or
14 where the defendant had -- was a physician who
15 had treated a transgender patient who then
16 committed suicide, and the state was trying to
17 take away his license to practice.

18 Q. The patient committed suicide?

19 A. Correct.

20 Q. Okay. Which party in that case
21 retained you?

22 A. The physicians.

23 Q. Okay.

24 A. Not the state.

25 Q. So this was the medical board of

1 whatever state this occurred in was trying to
2 take away the physician's license, right?

3 A. Correct.

4 Q. And were you retained as an expert
5 in that case to opine on what the standard of
6 care was for that physician when they were
7 rendering these medical services to the
8 transgendered patient?

9 A. Correct.

10 Q. And what did you conclude in that
11 case?

12 A. That testosterone treatment for
13 transgender men is recognized and appropriate,
14 and while providing treatment for transgender
15 patients diminishes their suicide risk, it
16 doesn't eliminate it, so I don't think
17 providing testosterone was the wrong thing to
18 do.

19 Q. Okay. Any other transgendered
20 cases?

21 A. I may have signed on to a couple of
22 Amicus briefs. Gavin Graham, I think, was one.

23 Q. That's a bathroom case, right?

24 A. I believe so. Well, facilities.

25 Q. Facilities case. Yeah, there was

1 locker room or something, right?

2 A. Correct.

3 Q. Okay. Any other that you -- any
4 others that you can recall?

5 A. In the last ten years -- oh,
6 actually, yeah. Zucker V. Cruz in New York,
7 which was sued on behalf of New York recipients
8 of Medicaid because the state wasn't
9 providing -- or wasn't paying for medically
10 necessary treatment for transgender Medicaid
11 recipients.

12 Q. I assume Gavin V. Grimm you signed
13 on to an Amicus brief on the plaintiff's side,
14 right?

15 A. Yes.

16 Q. And same goes for Zucker V. Cruz,
17 you -- you were retained as an expert witness
18 for the plaintiff suing the state to recognize
19 that Medicaid should pay for these services,
20 right?

21 A. Plaintiffs, yes. There's more than
22 one plaintiff.

23 Q. Oh, plaintiffs. Sorry.

24 Okay. And the identity document
25 case, obviously, you're an expert witness for

1 plaintiff, right?

2 A. In this case, yes.

3 Q. And then in the other identity
4 document case, you were an expert witness for
5 plaintiff, right?

6 A. Correct.

7 Q. Do you remember what type of
8 identity document was an issue in that other
9 identity document case?

10 A. Well, it's still ongoing. It's
11 driver's license.

12 Q. Driver's license. What's the issue
13 in that driver's license case?

14 A. That the state won't provide
15 amended or correct driver's licenses to
16 patients who are transgender.

17 Q. What state is that in?

18 A. Alabama. And I don't think it's a
19 matter that they won't, it's -- they won't
20 entirely, it's just that they have a surgical
21 requirement.

22 Q. Before they change the driver's
23 license?

24 A. Correct.

25 Q. Is this the only birth certificate

1 case you've been involved in?

2 A. I think so, yes.

3 Q. Other than the physician defendant
4 that you referenced where you testified that
5 the physician didn't violate the standard of
6 care or at least you opine that the physician
7 didn't violate the standard of care, have you
8 represented defendants in any other matters?

9 A. Physician defendants, no.

10 Q. Any other -- any other defendant?

11 A. Not that I can remember.

12 Q. Okay. So all the other times
13 you've been retained as an expert witness, it's
14 been on behalf of plaintiff or plaintiffs?

15 A. I think so. I'm not a lawyer, but
16 I think that's the case, yes.

17 Q. Have you ever been retained as an
18 expert witness for any state, government or
19 agency or anything like that?

20 A. I haven't been asked, so no.

21 Q. Okay.

22 MS. INGELHART: Excuse me. May we
23 take a quick break?

24 MR. BLAKE: Sure.

25 (Recess taken.)

1

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2

(Thereupon, Deposition Exhibit 19,
Expert Report, was marked for
purposes of identification.)

4

5

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6

Q. You've just been handed what has
been marked as Defendants' Exhibit 19. And
this is a copy of your expert report. Do you
recognize this document?

9

10

A. I do.

11

12

Q. We'll get to this in a little bit,
but in the back, I've also attached Exhibits A
and B to your report, which are your CV and
bibliography. Do those appear to be true and
accurate copies?

13

14

15

16

A. Again, I've added a couple of
things to my CV, but for the most part, yes.

17

18

19

Q. All right. Turn to Paragraph 4 on
the second page of the report. You listed a
few cases where you've testified as an expert
at trial or by deposition. You've listed
Corbitt V. Taylor, Edmo V. Idaho Department of
Corrections, Keohane V. Jones and Cruz V.
Zucker. Do you see that?

20

21

22

23

24

25

A. I do.

1 Q. Are those -- those are the only
2 cases you've testified as an expert witness in
3 the last four years?

4 A. Yes, that got to the point of
5 deposition or testimony.

6 - - - - -

7 (Thereupon, Deposition Exhibit 20,
8 Declaration, was marked for purposes
9 of identification.)

10 - - - - -

11 Q. Just handed you what's been marked
12 as Defendants' 20. If you turn to the second
13 page, it is an Eastern District of Wisconsin
14 case, Ashton Whitaker V. Kenosha Unified School
15 District. Do you see that?

16 A. I do.

17 Q. And it's a declaration that you've?
18 -- of Dr. R. Nicholas Gorton, M.D. That's you,
19 right?

20 A. Correct.

21 Q. And it looks like it's a 2016 case,
22 and this declaration was filed on
23 August 15th, 2016, right?

24 A. Yes.

25 Q. Is there a reason why this wasn't

1 included in Paragraph 4?

2 A. I don't think I did a deposition on
3 this or testimony at trial, and also, I did
4 forget about this, so...

5 Q. Okay. So no deposition or
6 testimony at trial, but there was a
7 declaration, right?

8 A. Yes.

9 Q. Okay. You can put that aside.
10 Corbitt V. Taylor, is that a case
11 that we talked about already?

12 A. That's one of the ongoing ones,
13 yes.

14 Q. Okay. Is that the driver's license
15 case?

16 A. Correct.

17 Q. And Edmo V. Idaho Department of
18 Corrections, I assume that's one of the prison
19 cases?

20 A. Yes.

21 Q. Keohane V. Jones?

22 A. That was a prison case in Florida.

23 Q. Also a prison case.

24 And Cruz V. Zucker, you mentioned
25 that one. That's the Medicaid case, right?

1 A. Correct.

2 Q. Is the driver's license case the
3 only ongoing case or are some of these others
4 still ongoing?

5 A. The other ones aren't ongoing.

6 Q. Okay. And what about Whitaker,
7 Defendants' Exhibit 20, is that one ongoing?

8 A. I honestly don't even know.

9 Q. Okay. Have you ever served as an
10 expert witness for Stacie Ray or any of the
11 other plaintiffs?

12 A. No.

13 Q. Have you ever served as an expert
14 witness for opposing counsel seated next to
15 you?

16 A. For their organization or for these
17 two people?

18 Q. For them individually.

19 A. No.

20 Q. Okay. Have you ever served as an
21 expert witness for attorneys from Lambda Legal?

22 A. Yes.

23 Q. Okay. In what cases have you
24 served as an expert witness for Lambda Legal?

25 A. Great question. Let me restate

1 that. I do work with Lambda Legal, and a lot
2 of these cases have, like, four co-counsels, so
3 I think one of them might have -- I can't tell
4 you specifically, but I do work with Lambda
5 Legal.

6 Q. So you think one or two times,
7 you've been an expert witness for cases where
8 Lambda Legal is involved?

9 A. I believe so, yeah.

10 Q. Do you know which cases?

11 A. I don't.

12 Q. Other than as an expert witness, do
13 you work with or for Lambda Legal?

14 A. I've done a few, like -- like, I
15 reviewed a couple of studies for them and gave
16 them my opinion on it, but it wasn't for a
17 specific case.

18 Q. So just some, like, very basic
19 consulting work?

20 A. Exactly.

21 Q. But as far as you know, that wasn't
22 in connection with any cases?

23 A. Not that I know of.

24 Q. Do you recall what studies they
25 asked you to review?

1 A. The Hayes report was one that I can
2 remember.

3 Q. Hayes report?

4 A. Yes, H-a-y-e-s.

5 Q. Any others?

6 A. That I can quote off the top of my
7 head, no.

8 Q. What is the Hayes report?

9 A. Hayes is a private company that,
10 for -- usually, clients that are large insurers
11 or other health care payors, analyzes medical
12 technologies or treatments, and this was their
13 analysis of transgender health care. I can't
14 tell you the exact title of the report, but it
15 was something like that.

16 Q. Do you know why you were asked to
17 review the Hayes report?

18 A. The original one that I reviewed
19 for Lambda Legal, I think it was because it was
20 being used by payors to deny care, and then
21 also an updated version was utilized in Cruz V.
22 Zucker, but that analysis, I didn't do with
23 Lambda Legal, it was with the attorneys in Cruz
24 V. Zucker.

25 Q. And so were you asked to criticize

1 or refute aspects of the Hayes report?

2 A. That came up in Cruz V. Zucker.
3 There were a lot of things that they said -- or
4 that Hayes said in the Hayes report that I
5 think ran counter to the standard of medical
6 treatment for trans patients, and so I had
7 opinions based on that. The original Hayes
8 report, they just sort of said tell us what you
9 think about this, and I don't know if it was --
10 I think it was probably being used to deny care
11 for patients, but I'm not exactly sure 'cause
12 this was, like, more than ten years ago.

13 Q. Oh, it was a long time ago?

14 A. Yeah. It was, like, 2006 or '7,
15 something like that.

16 Q. Pre-iPhone?

17 A. Exactly. Exactly.

18 Q. Dark ages.

19 I can probably guess, but what was
20 your opinion about the Hayes report?

21 A. The original One?

22 Q. Yes.

23 A. Was horrible and plagiarized.

24 Q. The Hayes report was horrible and
25 plagiarized?

1 A. Yeah. It had a tremendous amount
2 of systematic bias, and I figured out by
3 repeating their described search procedure that
4 the articles that they said they found, they
5 wouldn't have found that way, but those were
6 the same articles that were found by another
7 review that they cited, so...

8 Q. So they -- they cited -- they found
9 one source that compiled a bunch of other
10 sources, and you think that the Hayes report
11 just basically -- well, you said plagiarized,
12 but copied, right, copied that research?

13 A. I think they just used the articles
14 that the other report used because, like I
15 said, if you repeat their search strategy as
16 described in the paper, you don't get two of
17 the articles that they said they found with
18 that search strategy, and there were also a
19 couple of articles that they should have found
20 with that search strategy that were published
21 after the prior report was published, and so
22 two plus two usually equals four.

23 Q. And how does -- how did that
24 methodology of collecting resources undermine
25 any of the opinions in the Hayes report?

1 A. It certainly makes you think about
2 their other methodologies. So once you have
3 the papers that you're going to review, you
4 analyze them in a systematic way if you're
5 going a systemic review. And, in addition, in
6 the rest of the report, there was a systemic
7 bias, so papers that showed positive results,
8 they minimized and they also just completely
9 misinterpreted a couple of other studies. It
10 was not very well done.

11 Q. So the original Hayes report, in
12 your opinion, exhibited systemic bias and/or
13 misinterpreted several studies?

14 A. Yes.

15 Q. By the time you were hired as an
16 expert in Cruz V. Zucker, had the Hayes report
17 corrected what you understood to be errors?

18 A. Some of them, but not all of them,
19 and there was still a tremendous amount of
20 systemic bias.

21 Q. But you would agree, then, that
22 systemic bias is something to be avoided if
23 you're trying to create a valid study or report
24 of transgendered issues or, really, any issue,
25 medical issue, right?

1 A. You want to avoid all bias, but
2 people are human beings, so it's never possible
3 to be completely unbiased, but there are
4 well-known ways to reduce or eliminate it.

5 Q. Such as what? How do you eliminate
6 or avoid bias in a study?

7 A. So in something like the Hayes
8 report where you are looking at a whole bunch
9 of studies and doing a systemic review,
10 blinding people to who the authors were, having
11 multiple reviewers, also one thing that's
12 really important is to list the authors of the
13 paper and have the authors list their -- or
14 things that might bias them like I'm paid by
15 the drug company that manufactures the drug
16 that we're talking about. And, for example,
17 the Hayes report, no authors listed and no
18 biases listed, though if you go to their
19 website, most, if not all of their clients are
20 health care payors, which is a pretty
21 tremendous bias that should be declared, but
22 wasn't. And you can't tell the bias of the
23 individual authors because there were none
24 listed.

25 Q. So at least, I mean, is that

1 blinding the authors, then?

2 A. No. Blinding the authors would be
3 like showing you a paper and not knowing who
4 wrote it so you can't be like, oh, well, I know
5 Steve. He's not really good. And, also, too,
6 having multiple people review the same article,
7 so if I think it's positive in this way, you
8 think it's positive in this way, but a third
9 reviewer says, no, I think there's a
10 limitation, then you -- you know, you come to
11 consensus about what you think it ultimately
12 is.

13 Q. So if the Hayes report didn't list
14 their authors, how is that not -- how is that
15 not blinding the authors?

16 A. No. I'm not -- I was giving two
17 different examples.

18 Q. Okay. The problem with the Hayes
19 report isn't the blinding problem, the problem
20 with the Hayes report is that the potential
21 conflicts of the authors weren't disclosed?

22 A. Well, there's many problems. And,
23 for example, you can't tell a lot of what they
24 did because they just don't say it in the paper
25 like a normal systemic review would.

1 Q. Have you ever served as an expert
2 witness for the ACLU?

3 A. Yes.

4 Q. Approximately how many times?

5 A. This case, the Alabama case, maybe
6 they were co-counsel for Cruz V. Zucker. I'm
7 not sure.

8 Q. Okay.

9 A. I know one lawyer that I worked
10 with on Cruz V. Zucker is now an ACLU lawyer,
11 but I don't know if he was at the time, so...

12 Q. A few times?

13 A. That's fair.

14 Q. And have you ever done any other
15 non-expert witness consulting or work with the
16 ACLU?

17 A. Probably because I may just get
18 random e-mails from people saying what do you
19 think about this, so I'm on a number of
20 Rolodexes.

21 Q. So you think from time to time, you
22 just receive -- people from the ACLU reach out
23 and try to get your thoughts on one issue or
24 another?

25 A. That's fair.

1 Q. Is it generally transgender related
2 issues?

3 A. Yeah. That's --

4 Q. Exclusively?

5 A. I'm not sure about exclusively, but
6 that's my area of expertise, so...

7 Q. There's no one sending you a
8 question about free speech or something like
9 that, right?

10 A. No.

11 Q. Okay. Have you ever served as an
12 expert witness for attorneys with any other
13 group like Lambda Legal or the ACLU?

14 A. Sylvia Rivera Law Project, the
15 Legal Aid Society, many, many years ago, the
16 Northwest Justice Project, and I've not done a
17 legal case that I know of, but I've done some
18 work with NCLR around policies for trans
19 athletes to compete but not, like, a lawsuit.

20 Q. What is Sylvia Rivera?

21 A. Sylvia Rivera is a law project in
22 New York that focuses on transgender people,
23 especially those who are disenfranchised by
24 race or poverty.

25 Q. What was your involvement with

1 Sylvia Rivera?

2 A. Again, a lot of the kind of
3 curbsiding, hey, what do you think about this.
4 There was one case, again, many years ago,
5 where there was a prisoner in New York and they
6 were going to force her to have her head shaved
7 when she entered prison because they were
8 putting her in a male prison. The Cruz V.
9 Zucker case is the one that I'm not entirely
10 sure who the counsel was for because it was
11 somebody who had worked at SRLP and now works
12 for the ACLU, and so I don't know if that was
13 with them or not. I know the person, but not
14 who they were working for.

15 Q. Wouldn't surprise you if Sylvia
16 Rivera, that organization, was involved in the
17 Cruz case?

18 A. No, it wouldn't surprise me.

19 Q. And then Legal Aid, what kind of
20 work have you done with them?

21 A. I think they were involved in Cruz
22 V. Zucker.

23 Q. Is that all?

24 A. I think so.

25 Q. The Northwest Justice Project, what

1 is that organization?

2 A. That's a law organization in
3 Washington state that I worked with on two
4 cases for transgender patients who were being
5 denied payment for medically necessary care
6 under the state Medicaid agency.

7 Q. Those were two Medicaid cases?

8 A. Yes. And I -- I don't know if it
9 was considered testimony, but I phoned in and
10 talked to an administrative law judge, so I
11 think it was testimony, but it was -- it wasn't
12 I went to a physical court.

13 Q. Any other work for the Northwest
14 Justice Project?

15 A. Well, those were -- there were two
16 cases, but that was it.

17 Q. Okay. And then NCLR, you said you
18 did some work regarding policies for trans
19 athletes. Could you tell me more about that?

20 A. I've gone with them to talk to --
21 for example, I went with them to talk to the
22 California Boxing Board. I don't know if
23 that's the exact name, but the -- the
24 California state organization that regulates
25 boxing on behalf of a trans person who wanted

1 to compete. I went with them to talk to a
2 women's roller derby league once about changing
3 their policy, and I also worked with them in
4 providing some medical background and sort of
5 technical assistance when they were working
6 with the NCAA to draft their trans athlete
7 policies, and that was, like, in 2011, I think.
8 And I'm actually working with them now because
9 those are going to be reviewed, but that's in
10 process.

11 Q. Okay. Other than that one case you
12 mentioned where you were representing or the
13 expert witness for a physician defendant,
14 have -- has all of your work as a medicolegal
15 consultant or expert been on behalf of advocacy
16 groups like Lambda Legal, Northwest Justice
17 Project, ACLU, et cetera?

18 A. There -- I've worked with legal
19 groups, and like I said, also NCLR on more of
20 a -- not a lawsuit thing, but just technical
21 assistance to help them and to help the NCAA
22 write their policy. I should also add, I've
23 actually worked with the Transgender Law Center
24 too, though not in the past few years.

25 Q. Is that another group like Lambda

1 Legal?

2 A. It's a California-based
3 organization that, many years ago, was more of
4 a direct services organization, and now they
5 don't do that as much, and so when they were
6 doing direct services, I did more work with
7 them on behalf of the individual clients, like
8 not going to court, but talking to some third
9 party that had a sex-segregated facility and
10 saying, gee, this is why you should let trans
11 women use the women's facilities and trans men
12 use the men's facilities.

13 Q. What is a direct services
14 organization? What do you mean by that?

15 A. Instead of -- like, the ACLU
16 provides services to clients, but they're not
17 providing more mundane services, so they worked
18 with a lot of people just to get their driver's
19 license changed in California. Even though
20 it's a pretty easy process to do that, some
21 people, because they lack experience or
22 resources, find that difficult, so they would
23 work with a lot more individual clients.

24 Q. Okay. You've mentioned a few cases
25 where you served as an expert witness involving

1 challenges to laws or regulations by the
2 government, right?

3 A. I'm not sure what you --

4 Q. Well, the driver's license case,
5 that's a law or regulation prohibiting people
6 in Alabama from having the sex identifier on
7 their driver's license from changing unless
8 they had a certain amount of surgery, right?

9 A. Correct.

10 Q. In this case, it's a challenge to a
11 law or regulation involving when the sex
12 identifier on a birth certificate be changed,
13 right?

14 MS. INGELHART: Objection. Calls
15 for a legal conclusion, but you can answer.

16 THE WITNESS: Yeah. My question
17 was did you mean the Medicaid cases and the
18 payor cases? 'Cause those are agencies, but
19 they're not --

20 Q. It's a regulation promulgated by a
21 governmental agency?

22 MS. INGELHART: Again, objection.

23 Q. If you don't know, you don't know.

24 A. I think a lot of those cases
25 were -- like, the prison cases, they have

1 policies in the prison that say we don't do X.

2 Q. Right. And that's -- you know, the
3 policy of the prison itself or maybe the Bureau
4 of Prisons or whatever the equivalent is in
5 whatever state you're testifying in, right?

6 A. Exactly.

7 Q. In any matter that you've been
8 retained as an expert witness involving a
9 challenge to a law, regulation or governmental
10 policy, have you ever concluded that such law,
11 regulation or policy was valid?

12 MS. INGELHART: Objection. Calls
13 for a legal conclusion. You can answer.

14 THE WITNESS: I generally think
15 about it as the particular medical needs of the
16 plaintiffs in these cases, and so I'm not so
17 much saying this isn't valid, I'm saying for
18 these people, this is not appropriate. It's
19 not what is the standard of medical treatment
20 to transgender patients.

21 Q. So you -- you don't -- you haven't
22 offered an opinion on the validity of any law,
23 regulation or policy?

24 MS. INGELHART: Objection. You can
25 answer.

1 THE WITNESS: I don't -- I don't
2 really know if you would consider what I've
3 said in those cases to be a challenge to it,
4 but if, for example, there's a law that -- or
5 there is a policy that says transgender people
6 shouldn't, in any circumstances, get surgery,
7 then, yeah, I think that's wrong because in
8 many cases, transgender people do need surgery.
9 As far as saying this should be changed, how it
10 should be changed, my -- my point is usually
11 whether or not something is medically
12 appropriate. I'm not a lawyer, so...

13 Q. You're not looking at the
14 constitutionality of something or whether the
15 government has a right to do a thing, your
16 testimony or opinion has always been regarding
17 whether or not the outcome of the policy or law
18 is medically appropriate for the plaintiff,
19 right?

20 A. I think that's fair, yeah.

21 Q. And I don't want to try to confuse
22 you. In the Alabama case, for example,
23 there -- they don't allow transgendered
24 individuals to change their driver's license
25 unless they've had a certain amount of surgery,

1 you've already testified to that. Your opinion
2 isn't that that law is somehow unconstitutional
3 or illegal, it's that for those plaintiffs,
4 it's medically appropriate for them to change
5 their driver's license without that amount of
6 surgery, right?

7 MS. INGELHART: Objection. Calls
8 for a legal conclusion. You can answer.

9 THE WITNESS: I couldn't tell you
10 if something's constitutional or not. I mean,
11 I took civics in high school and a few classes
12 in college and history, but that's not my area
13 of expertise. But I can say that for
14 individual patients or for the transgender
15 community at large, something is inappropriate.
16 For example, in the Alabama, there might be
17 people who have medical contraindications to
18 surgery, and saying you can't have this
19 important element of social transition because
20 it's too medically dangerous for you to get
21 this other medically necessary treatment is
22 just bonkers. It's -- it's not appropriate.

23 Q. Okay. And in this case, it's your
24 opinion that it would be medically appropriate
25 for the plaintiffs here to be able to change

1 the sex identifier on their birth certificate,
2 right?

3 A. I think it's medically necessary
4 for transgender patients to be allowed to
5 change the gender marker and the name on all of
6 their identity documents.

7 Q. Have you been asked by plaintiffs'
8 counsel to provide a rebuttal to the opinion
9 submitted by Dr. Van Meter and his expert
10 report?

11 A. I think in my report, I actually
12 commented on Dr. Van Meter's report.

13 Q. Yeah. So that's my question is
14 have you been asked by plaintiffs' counsel to
15 provide a rebuttal to the opinion provided by
16 Dr. Van Meter and his expert report?

17 A. They gave me a copy of his report
18 and they said if you think anything's important
19 to comment on in your report, comment on it.

20 Q. And what you're just leafing
21 through there, Defendants' Exhibit 19, those
22 comments are included in that report, right?

23 A. Yes.

24 Q. In fact, Paragraph 2 of your report
25 says: I have been asked by plaintiffs' counsel

1 to provide my expert opinion to respond to and
2 rebut the opinions offered by Dr. Quinton L.
3 Van Meter in his expert report in order to show
4 how Ohio's policy refusing to provide accurate
5 birth certificate gender markers for
6 transgendered people born in Ohio harms
7 transgender individuals.

8 You see that, right?

9 A. Yes.

10 Q. Is that the only opinion you were
11 asked to render in this matter?

12 A. I was asked to talk about the --
13 the policy, the central element to, I think,
14 what this litigation's about, like should
15 transgender people be allowed to change their
16 birth certificate.

17 Q. And you said "the policy." You're
18 talking about the policy of defendants to not
19 allow transgendered individuals to change their
20 birth certificate on -- to change the birth
21 certificate because of their gender identity,
22 right?

23 A. Correct.

24 Q. Did you -- before rendering that
25 opinion, did you review any materials?

1 A. I reviewed the -- I think it's
2 called the complaint, like, the suit premises,
3 I guess. I reviewed Dr. Van Meter's report.
4 In the course of all of this, I reviewed
5 Dr. Ettner's report, but I don't think that was
6 before I wrote my report. I'm not entirely
7 sure, but I don't think so. I think that's it.
8 I mean, there's been a couple other things that
9 they've sent me subsequently, but that was the
10 crux of -- the complaint and Dr. Van Meter's
11 report.

12 Q. What other things did they send to
13 you?

14 A. Like I said, Dr. Ettner, I think
15 Dr. Van Meter wrote a report about Dr. Ettner's
16 report.

17 Q. So his rebuttal report?

18 A. I think that's what you call it,
19 yes. I think that's it, but there might have
20 been something small in addition, but those are
21 the ones that I remember that stand out to me.

22 Q. Do you -- well, which opinions of
23 Dr. Van Meter did you rebut in your -- or
24 respond to in your report?

25 MS. INGELHART: Objection. Vague.

1 You can answer.

2 THE WITNESS: In regards to
3 Dr. Van Meter's report, I think he came to
4 conclusions that are very much in contradiction
5 to what is accepted by the broader medical
6 community as far as treating trans patients,
7 and his views on that are pretty fringe. I
8 think he also underestimated the number of
9 people who have DSDs. He also seemed to say
10 that there was no biologic basis for people
11 being transgender, and I think the research
12 literature doesn't support that. I think he
13 also underestimated the incidence of
14 transgender people in general. I think his
15 assumption about the karyotypes of the
16 plaintiffs and being sort of absolutely
17 definitive about that was -- nothing was a
18 scientifically accurate way to describe that
19 because we know that transgender people, when
20 compared to cisgender or non-transgender people
21 actually have a higher rate of abnormal
22 karyotypes. I may have said other things, but
23 I think those are the high points.

24 Q. Did you provide an opinion
25 regarding the harm caused by inaccurate birth

1 records to transgendered people?

2 A. Yes.

3 Q. Do you know whether Dr. Van Meter
4 provided an opinion as to harm or potential
5 harm caused by inaccurate birth records?

6 MS. INGELHART: Objection.
7 Foundation, but you can answer.

8 THE WITNESS: I think he had the
9 opinion that birth records should not be
10 changed, and while I don't think he described
11 the harms that would come from that, I think
12 the harms that would come from that are pretty
13 obvious to anybody who takes care of a lot of
14 transgender people. I don't have his report in
15 front of me, though, so I can't tell you for
16 sure, but I don't recall him specifically
17 saying, yes, we shouldn't allow people to
18 change their identity documents and these are
19 the bad things that will happen to them if we
20 do or if we don't.

21 Q. This was a document which was
22 previously marked as Defendants' Exhibit 19 --
23 or 18, sorry, which is the expert report of
24 Dr. Van Meter. Where in this report does
25 Dr. Van Meter conclude that birth records

1 should not be changed?

2 A. On Page 5 in his conclusions, he
3 says that No. 29: Ohio birth certificates
4 record an individual's sex.

5 Q. Do you disagree with that?

6 A. I disagree with Dr. Van Meter's
7 definition of sex in subsequent paragraphs.

8 Q. Okay. So do you disagree with the
9 statement that Ohio's birth certificates record
10 an individual's sex?

11 A. Using my definition of "sex" and
12 not Dr. Van Meter's, I think that's reasonable,
13 but I also don't think it's always correctly
14 recorded.

15 Q. How does your definition of "sex"
16 differ from Dr. Van Meter's?

17 A. From his points in his conclusion,
18 it seems that he says that chromosomes are the
19 determinant of sex and always align with what
20 he thinks sex is, and that that should be what
21 is utilized for Ohio's birth certificate.

22 Q. And you disagree with that because?

23 A. I think it's very simplistic to
24 think that sex is only what your external
25 genitals look like or what your chromosomes are

1 or that what your external genitalia look like
2 reflects what your chromosomes look like. I
3 think sex is a much more complicated concept.

4 Q. If you turn to Paragraph 3 of
5 Dr. Van Meter's report, there's a heading that
6 says -- sorry, not Paragraph 3, Page 3, there's
7 a heading that says: Biological sex is binary.
8 Let me know when you're there.

9 A. I'm there.

10 Q. And if you look at Paragraph 14, it
11 says: From the moment of conception, a fetus
12 is determined to be either a male XY, female
13 XX, or in rare cases to have a combination sex
14 determining chromosomes.

15 Do you disagree with that
16 statement?

17 A. I think that at conception, every
18 fetus has sex chromosomes. Most of the time,
19 those are either XY or XX. In rare cases,
20 though not as rare as he suggests later in his
21 report, those are either not XX or XY. They
22 might be just one X, two Ys, or in some cases,
23 the gene on the Y chromosome that sends you
24 down the typically male developmental pathway
25 is actually moved onto the Y chromosome.

1 Although while chromosome abnormalities are
2 often not compatible with life, actually sex
3 chromosome abnormalities are some of the ones
4 that are the most compatible with life.

5 Q. So you disagree with Dr. Van Meter
6 on the rate of such abnormalities, but just so
7 everyone is on the same footing, I mean, are we
8 talking about one percent of the time, half a
9 percent of the time, three percent of the time?

10 A. I'd say half to a quarter of a
11 percent of the time.

12 Q. Okay. So he may be, you know, a
13 hundredth of a percent of the time or whatever,
14 but you still acknowledge that it's exceedingly
15 rare these type of chromosomal abnormalities,
16 right?

17 MS. INGELHART: Objection.
18 Mischaracterizes prior testimony, but you can
19 answer.

20 THE WITNESS: One in 200 isn't
21 exceedingly rare. That's more common than kids
22 who have cystic fibrosis or kids who have
23 sickle cell, so it's not exceedingly rare.
24 It's uncommon, it's rare.

25 Q. Okay. So I guess without getting

1 into the definition of how he's using the word
2 "rare," you would agree, then, that from the
3 moment of conception, a fetus is determined to
4 be either male, XY; female, XX; or in rare
5 cases, to have a combination of sex determining
6 chromosomes, many of which are not compatible
7 with life, and some of which are the cause of
8 identifiable clinical syndromes. You agree
9 with that, right?

10 MS. INGELHART: Objection.
11 Mischaracterizes prior testimony. You can
12 answer.

13 THE WITNESS: I don't think that's
14 exactly what I said. I think what I said was
15 that at fertilization, most fetuses are XX or
16 XY, and if you're XY, it sends you typically
17 down the pathway for male reproduction, but
18 that doesn't determine your sex. That's one
19 aspect of biologic sex that should be taken
20 into consideration, but is not the determining
21 factor for sex.

22 Q. And when you say "most," you mean
23 99 out of a hundred or less?

24 A. Ninety-nine out of a hundred or
25 less is --

1 Q. If you could go back to Page 5 of
2 Dr. Van Meter's report.

3 A. I'm there.

4 Q. And you look at Paragraph 30, it
5 says: Gender identity is not observable or
6 detectable at the time of birth.

7 Do you see that?

8 A. Yes.

9 Q. Do you agree with that conclusion?

10 A. Not entirely.

11 Q. You believe that there are
12 mechanisms by which you can detect gender
13 identity at the time of birth?

14 MS. INGELHART: Objection.
15 Misstates, mischaracterizes prior testimony.
16 You can answer.

17 THE WITNESS: In the case of
18 children with intersex conditions, that we have
19 reasonable research that tells us as adults,
20 this child is likely to identify as male or
21 female, you can talk about that. So you can
22 say in XY fetuses that are born with complete
23 androgen insensitivity syndrome, virtually all
24 of them identify as women in adulthood, whereas
25 XY fetuses who have five alpha reductase

1 inhibitor deficiency, it's 60/40 as to whether
2 or not they identify as male or female in
3 adulthood. You can also say with most people
4 who don't have an intersex condition, that if
5 they're XY, they'll identify as male in
6 adulthood and if they're XX, they'll identify
7 as female, so you can make an educated guess,
8 but that's going to be wrong sometimes.

9 Q. So if you turn to your report,
10 Defendants' Exhibit 19 and you turn to Page 4,
11 look at Paragraph 14, let me know when you're
12 there.

13 A. I'm there.

14 Q. You define gender identity as the
15 internal sense of one's self as, for example,
16 being a male or female. Do you see that?

17 A. I do.

18 Q. What -- how can you determine
19 someone's gender identity as a newborn if it is
20 the internal sense of one's self?

21 A. As I said, you can make an educated
22 guess based on information available to you at
23 the time. So if you have an XY fetus that has
24 complete androgen insensitivity syndrome, it's
25 a pretty good guess that that child is going to

1 identify as female in adulthood. If you have
2 an XY baby who -- that we can find has no
3 detectable intersex condition, you can make an
4 educated guess that as an adult, that child is
5 going to identify as female. So you can't say
6 with certainty, but you can say the odds that
7 something is going to be the case.

8 Q. So isn't that what's already
9 happening when a child is born in Ohio in and
10 the medical provider looks at the external
11 genitalia, they say that looks like male
12 external genitalia. Pretty good guess that
13 that's an XY chromosome child, right?

14 A. Exactly. It's a pretty good guess.

15 Q. And then it's a pretty good guess,
16 based on your testimony, that their internal
17 sense of one's self, their gender identity is
18 also going to be male, right?

19 A. Again, that's a good guess.

20 Q. Okay. But you can't know for
21 certain what the gender identity of a child is
22 going to be based on their external genitalia,
23 right?

24 A. Or karyotyping or anything.

25 Q. Or karyotype or if they're born

1 with intersex conditions, right?

2 A. Correct.

3 Q. Certainly can't ask them?

4 A. Not at that age, no.

5 Q. Getting back to Dr. Van Meter's
6 report, and I just want to close sort of this
7 line of questioning. Where in Dr. Van meter's
8 report does he discuss potential for harm
9 caused by the policy of defendants or the law
10 related to when Ohio will change the sex
11 identifier on a birth certificate?

12 A. Again, I don't see where he did
13 talk about the harm that this experience by
14 trans people who don't have accurate identity
15 documents.

16 Q. So to the extent your report gives
17 an opinion on the harm that's caused by the
18 mismatched identity documents, that's not in
19 response to Dr. Van Meter, right?

20 MS. INGELHART: Objection.
21 Mischaracterizes testimony in the report, but
22 you can answer.

23 THE WITNESS: Well, there's two
24 answers to that question. The first is my
25 opinion about that is based on my almost 15

1 years of experience treating a lot of
2 transgender patients, many of whom weren't able
3 to easily change their gender identity
4 documents, and so seeing the harms that those
5 people suffer. But I think, also, when I heeded
6 Dr. Van Meter's report, it seems to me that he
7 thinks that it is appropriate to not change
8 identity documents for transgender people. It
9 may be the case that he just has not taken care
10 of enough transgender people to realize what
11 harms they suffer, and I always assume that
12 people are trying to do the right thing, and so
13 he doesn't talk about that, but I think that's
14 an omission on his part and a lack of
15 understanding on his part.

16 Q. So he doesn't talk about whether or
17 not it's appropriate to change identity
18 documents, right?

19 MS. INGELHART: Objection.
20 Mischaracterizes, but you can answer.

21 THE WITNESS: No. I think he does
22 talk about it.

23 Q. Where does he talk about the
24 appropriateness of changing an identity
25 document?

1 A. In his conclusions, he says: Ohio
2 birth certificates record an individual's sex.
3 That's Paragraph 29. And then he goes on to
4 state that the plaintiffs' sex is --
5 essentially, their sex is assigned at birth.
6 So taking those two points together, it seems
7 he thinks that the sex you're assigned at birth
8 should be the sex that determines your -- or
9 the sex that is listed on your birth
10 certificate.

11 Q. But he doesn't explicitly say that,
12 right?

13 MS. INGELHART: Objection. You can
14 answer.

15 THE WITNESS: I mean, it's kind of
16 obvious. He says they record sex. I think the
17 plaintiffs' sex are not what the vast majority
18 of transgender health care providers would
19 describe as their sex. And, you know, if he
20 says it should record sex and this person's sex
21 is male, he's essentially saying that person's
22 sex should be recorded on their birth
23 certificate as male.

24 Q. And then he doesn't go into whether
25 or not that would harm them in any way, right?

1 A. Not that I recall, but I -- it took
2 me a while to read his report, so rereading it
3 again here would take some time too.

4 Q. Did you reduce all of your opinions
5 in this matter into your written report?

6 A. There's a -- this is a very
7 complicated subject, so I gave what I think is
8 a summary of my opinions. But did I put every
9 bit of knowledge that I have that informs that
10 in there, no.

11 Q. Okay. Are you being compensated
12 for rendering your opinion in this matter?

13 A. Typically, in cases where the
14 plaintiffs' attorneys are representing the
15 plaintiff pro bono, I waive compensation for
16 hours, but I do expect my travel time
17 compensated -- or not travel time, travel
18 expenses compensated. So in this case, I
19 waived, for the ACLU, my expert witness fee
20 because they are representing these patients
21 pro bono.

22 Q. But you expect to be compensated
23 for your expenses, flight, hotel room, things
24 like that, right?

25 A. Exactly.

1 Q. All right. Exhibit 19 also
2 includes a copy of your CV and bibliography,
3 Exhibits A and B, right?

4 A. Yes.

5 Q. All right. If you turn to
6 Exhibit B, which is a copy of the bibliography,
7 are these materials that you relied on to form
8 your opinion in the report?

9 A. They're things that I cited in my
10 report and there are a few things that, for
11 example, the National Transgender
12 Discrimination Survey, that has a lot more
13 information than what I may have cited in my
14 report. And so some of these things are
15 citations and some of these things are, I
16 think, important data points from the
17 literature.

18 Q. Okay. So to the extent that items
19 in your bibliography are cited in your report,
20 you would have relied on them in forming the
21 opinions in your report, right?

22 A. Those places where they were
23 particularly cited.

24 Q. Okay. Are there any other
25 materials in the bibliography that you relied

1 on in forming the opinions in your report?

2 A. For example, the standards of care,
3 I mean, that's sort of how I practice.

4 Q. Are you talking about the WPATH
5 standards of care?

6 A. Yes. Correct.

7 Q. Where are those located?

8 A. It's on the first page, halfway
9 down, Coleman E., Bockting.

10 Q. Okay. Anything else?

11 A. The Toronto guidelines are a good
12 example of trans health care or guidelines.

13 Q. Where is that one?

14 A. That's just above the other one,
15 Bournes, A.

16 Q. Okay. Any other ones?

17 A. I'm honestly not sure which ones
18 are cited ones or which ones aren't.

19 Q. Well, the ones that are cited are
20 cited in there. Those ones are just easy to
21 find, right? I mean, you've got TransLine,
22 footnote one, retrieved from [http](http://project-health.org/TransLine)
23 project-health.org/TransLine. I don't know if
24 that's in your bibliography, but that was
25 something that was cited, right?

1 A. So let's just go down them. So the
2 first one, the AAP, I think that was a
3 citation. The second one, the APA Task Force,
4 that may have been a citation, but it's also
5 just kind of a good general document. Bauer, I
6 cited. Bentz, I cited. Bournes, we talked
7 about. Byne and Bradley, that might be a
8 citation, but it's also just generally a good
9 document. We talked about the standards of
10 care. Collin, I cited. Coolidge, I cited.
11 Diamond, I cited. Fraser, I'm not sure if I
12 cited, but it's also just generally a good
13 article. My own paper, I'm not actually sure
14 if I cited it. I know that sounds dumb. The
15 National Transgender Discrimination Survey, we
16 talked about. Hare was a citation. Hembree is
17 the Endocrine Society's guidelines, so I may
18 have cited that, but that's also just a
19 generally good document. Henningsson, I cited.
20 Inoubli, I cited. James, et al., it's that
21 same National Transgender Discrimination
22 Survey. Lee, I cited both of them. Lehavot, I
23 cited. Makadon is, again, just a good guide.
24 I may have cited it, but I'm not sure. Seaborg
25 is a citation that Dr. Van Meter used, so I

1 went -- in commenting that, I cited it.
2 Southern Poverty Law Center, I cited when
3 talking about the American College of
4 Pediatrics. And Wieckx, I probably cited that,
5 but it's also just a good general study that I
6 may have included.

7 Q. All right. So, I mean, it sounds
8 like you relied on pretty much everything in
9 your bibliography, then, right?

10 A. Some things are specific citations
11 and some things are just generally good
12 transgender medicine.

13 Q. All of which you relied on in
14 forming the opinions in your report, right?

15 A. In some way or other, yes.

16 MS. INGELHART: Excuse me. Could
17 we take another break? You're close? I can
18 wait.

19 MR. BLAKE: Let's finish up
20 bibliography stuff and then we'll break for
21 lunch.

22 MS. INGELHART: Sure.

23 Q. Other than the materials we
24 discussed, you know, the complaint, the report
25 of Dr. Van Meter, Dr. Ettner's report,

1 materials in your bibliography, did you review
2 or rely on anything else in preparing your
3 expert opinion?

4 A. In preparing my report?

5 Q. Uh-huh.

6 A. Not that I can think of, but
7 there's a lot of literature that I have in the
8 brain, so...

9 Q. I get it, that some knowledge is
10 just general knowledge, right? I mean, in some
11 way, shape or form, you're relying on stuff you
12 learned in medical school?

13 A. Exactly.

14 Q. But talking specific to this
15 report?

16 A. Correct.

17 Q. And did you review, at any time,
18 whether in preparation for the report or
19 subsequent to your report, did you review the
20 motion to dismiss or any of the related
21 pleadings?

22 A. I reviewed the motion to dismiss,
23 which they sent me last week, maybe.

24 Q. Okay. So that was in preparation
25 for today?

1 A. I think that was -- I don't know if
2 it was in preparation, but this is part of the
3 case, so...

4 Q. Okay. Did you review the order
5 related to the motion to dismiss?

6 A. What the judge said?

7 Q. Yes.

8 A. I actually think -- I'm not sure --
9 I read the judge's response to that.

10 Q. Okay. Not the pleadings underlying
11 the order?

12 A. I don't think so.

13 Q. Okay. Did you review any of
14 plaintiffs' discovery responses?

15 A. I don't know what that is.

16 Q. Okay. Then I'll take that as "no"
17 for now, and if we look at them later and you
18 say "I did see this," I won't crucify you for
19 it.

20 A. Sure.

21 Q. Did you interview any of the
22 plaintiffs at any time?

23 A. No.

24 Q. And I assume you haven't conducted
25 any medical or psychological examinations of

1 the plaintiffs?

2 A. No.

3 Q. Have you ever met any of the
4 plaintiffs in this matter?

5 A. Not that I know of.

6 Q. Have you spoken to anyone else
7 aside from your counsel, but have you spoken to
8 anyone else in connection with this matter
9 since rendering your opinion?

10 A. No.

11 MS. INGELHART: Objection. Vague.
12 I'm sorry. You can answer.

13 THE WITNESS: No. Just the
14 attorneys.

15 MR. BLAKE: All right. Yeah, we
16 can take a break.

17 MS. INGELHART: Cool.

18 (Luncheon recess taken.)
19
20
21
22
23
24
25

AFTERNOON SESSION

CONTINUED EXAMINATION OF RYAN GORTON, M.D.

BY MR. BLAKE:

Q. We're going to turn to Exhibit A of your expert report, Defendants' Exhibit 19. Go ahead and turn to Exhibit A.

A. Okay.

Q. And this is a copy of your CV, correct?

A. Correct.

Q. You noted there was an update regarding the GEI certification, right?

A. Yes, and one additional talk.

Q. Okay. So would that GEI certification, would that be listed now under your licensure and certification?

A. Yes.

Q. And fair to say September 2019 through present?

A. I think they --

Q. October?

A. It might have been the first of October they sent me the result.

Q. Okay. So October 2019 through present, that's the GEI?

1 A. Correct.

2 Q. And you said there was one
3 additional talk?

4 A. Yes. I gave a plenary at the Gay
5 and Lesbian Medical Association in September.

6 Q. Okay. So September plenary at --
7 I'm sorry, the what again?

8 A. GLMA, the Gay and Lesbian Medical
9 Association, GLMA.

10 Q. Okay. Any other updates?

11 A. No.

12 Q. Okay. So your professional
13 practice, you've listed the things we talked
14 about earlier, your work at Sutter Davis, the
15 work at Saint Tammany, and you have, underneath
16 volunteer activities, this Lyon-Martin work; is
17 that accurate?

18 A. Yes.

19 Q. So are you paid for the primary
20 services you provide at Lyon-Martin?

21 A. No. I work pro bono there.

22 Q. But you're paid for your work at
23 Sutter Davis, right?

24 A. Yes.

25 Q. You've never worked as a

1 psychologist, right?

2 A. No.

3 Q. And your medical training is not in
4 the field of molecular geneticist, right?

5 A. Genetics is a part of medical
6 school, but I don't have a degree in that.

7 Q. Okay. You're not an expert in
8 genetics?

9 A. I have as much expertise in
10 genetics as most physicians would have.

11 Q. But not as much as a geneticist?

12 A. Correct.

13 Q. And you don't have any expertise in
14 endocrinology either, right?

15 A. Again, that's a part of general
16 medical practice, and so I treat patients with
17 endocrine disorders, but I do it as a primary
18 care provider.

19 Q. And I have any -- well, do you
20 refer your patients to endocrinologists as part
21 of your practice?

22 A. Rarely, but sometimes.

23 Q. When there's, like, some sort of
24 special need to do so?

25 A. Often, it's diabetes management.

1 Q. Okay.

2 A. That is more than typical diabetes
3 management of primary care.

4 Q. So like your familiarity with
5 genetics, would you say that your knowledge of
6 endocrinology is as much as any other
7 physician?

8 A. I would say probably a little more
9 than average in that I treat a lot of
10 transgender patients and their endocrinology
11 issues with those, so as part of my practice, I
12 do more of that.

13 Q. But your expertise would be
14 certainly less than someone who's a trained
15 endocrinologist, right?

16 A. Yes. Absolutely.

17 Q. Your professional affiliations, are
18 those also current on Page 2?

19 A. The two in the middle are prior
20 ones that I gave years for. I'm still a WPATH
21 member and I'm still -- I'm the GLMA medical
22 expert's panel, which is basically just a
23 running list of people that can refer to.

24 Q. For the World Professional
25 Association for Transgendered Health

1 Membership, what are the qualifications to be a
2 member of that organization?

3 A. To be a member, I don't know if
4 there's a specific restriction. I mean, there
5 are students who are members, there are medical
6 professionals, mental health professionals,
7 some lawyers who are members, so I don't think
8 there's a cutoff for it. Obviously, for GEI
9 certifications, there is, and if you
10 participate in committees, it's usually because
11 you have some expertise in that area.

12 Q. Usually, but not always?

13 A. I'm not on all the committees, so I
14 don't know who's on all the committees, so I
15 couldn't tell you, but...

16 Q. The Transgender Medicine Research
17 Committee and the Institutionalized Persons
18 Committee, do those require any special degree
19 or certification to be a member of the
20 committee?

21 A. Medicine Research Committee, I
22 think it's more of your interest in it.
23 Medical students can be members. The
24 Institutionalized Persons Committee, I don't
25 know if there's requirements, but most of the

1 people there have experience in that area. In
2 fact, everybody that I know who's on it has
3 experience in that area and you're asked to
4 participate if you're knowledgeable.

5 Q. Okay. But you're not aware of any
6 specific criteria or certification which you
7 need in order to join either of those
8 committees?

9 A. That I know of, no.

10 Q. Are you an officer at WPATH?

11 A. No.

12 Q. Would you agree that WPATH's -- one
13 of WPATH's primary missions is advocacy on
14 behalf of transgendered folks?

15 MS. INGELHART: Objection. Vague.
16 You can answer.

17 THE WITNESS: In the sense that
18 health care providers, in treating many
19 different conditions, have to be advocates for
20 their patients, yes.

21 Q. You've listed about two pages worth
22 of publications and papers on Pages 2, 3 and 4
23 of your CV. Do you see that?

24 A. I do.

25 Q. Did you rely on any of these

1 publications or papers to form the opinions
2 expressed in your expert report?

3 A. A lot of the knowledge that
4 informed my expert report was the same
5 knowledge that informed writing those papers or
6 co-writing those papers, and so the knowledge
7 base is the same, but it's not like I went back
8 to one of these and read it before I created my
9 report.

10 Q. Did you go back and look at any of
11 them in creating your report?

12 A. If I used the first one, Gorton and
13 Berdahl, as a citation, I think I may have gone
14 back to look at that to get the correct point.

15 Q. Okay. Any others?

16 A. That I remember, no.

17 Q. Same question for your
18 presentations, did you go back and look at or
19 rely on any of the materials that are -- that
20 were part of these presentations or talks?

21 A. That I can think of directly, no.

22 Q. All right. Go to Paragraph 14 of
23 your opinion. It's on Page 4 of Defendants'
24 Exhibit 19. Are you there?

25 A. I'm there.

1 Q. All right. This is the definition
2 of gender identity that we read and discussed
3 earlier. Do you recall that?

4 A. I do.

5 Q. Are there any other definitions of
6 gender identity that you're familiar with?

7 A. There are a lot of different ways
8 of stating this, but I think the general idea
9 that gender identity is the internal sense of
10 one's self as a man or a woman or somewhere on
11 the spectrum between those is reasonably
12 accepted.

13 Q. You didn't use "spectrum" here to
14 describe gender identity, did you?

15 A. No. I just used, for example,
16 being male or female because that's the most
17 common identities.

18 Q. But you would also include the
19 concept of a spectrum as also defining gender
20 identity?

21 A. There are transgender patients that
22 I've treated who don't feel like they belong in
23 either the male or female category and that
24 they're somewhere along that spectrum, and so,
25 yeah, people do define that way.

1 Q. Okay. Let's look back at
2 Defendants' 20, which is the declaration you
3 gave in the Whitaker case. And if you turn to
4 Page 4 of that document and look at
5 Paragraph 11, let me know when you're there.
6 Are you there?

7 A. Yes.

8 Q. Gender identity is each
9 individual's internal sense of themselves as
10 belonging to a particular gender such as male
11 or female. So similar to what you described in
12 your expert report in this case in
13 Paragraph 14, but not identical, right?

14 A. No, because I might write the same
15 thing slightly different.

16 Q. But in your mind, those two are
17 pretty close?

18 A. Yes.

19 - - - - -

20 (Thereupon, Deposition Exhibit 21,
21 Declaration, was marked for purposes
22 of identification.)

23 - - - - -

24 Q. You've just been handed what has
25 been marked as Defendants' Exhibit 21, and if

1 you flip through it, you'll see that this is a
2 declaration that you provided in the case of
3 Edmo versus Idaho Department of Correction. Do
4 you see that?

5 A. Yes.

6 Q. Does this appear to be a true and
7 accurate copy of that declaration?

8 A. I haven't read the whole thing, but
9 I'm assuming it's correct.

10 Q. Okay. If you go to Paragraph 18,
11 which is on page -- well, 35 of 100 of the
12 document, but Page 6 of the declaration, you
13 define gender identity as the hardwired
14 internal sense of one's gender. Do you see
15 that?

16 A. Yes.

17 Q. That's a very different definition
18 than you used in the other two declarations,
19 correct?

20 MS. INGELHART: Objection.
21 Misstates and mischaracterizes prior testimony.

22 THE WITNESS: I don't see that.

23 Q. Well, what did you mean by
24 "hardwired"?

25 A. That in adults, this isn't

1 something that really changes.

2 Q. Okay. So how is that similar to
3 what you've defined as the internal sense of
4 one's self as, for example, being a male or
5 female?

6 A. So in adults, people have a gender
7 identity. Everyone has one. Transgender
8 people, non-transgender people, and it doesn't
9 really change in adulthood to an appreciable
10 amount.

11 Q. So what does gender identity have
12 to do with being an adult?

13 A. Gender identity in preadolescent
14 children can sometimes be fluid and change.
15 Typically, once early adolescence has
16 commenced, it's fairly fixed, and by adulthood,
17 completion of puberty, it's not really
18 something that can be changed.

19 Q. So I don't see that in your
20 definition -- any of these definitions, gender
21 identity, this concept of fluidity as a child
22 or being fixed as an adult. Is that somehow
23 implicit in some of the words that you've
24 chosen to use here?

25 A. In each of these documents, I'm

1 trying to explain a very nuanced concept, and
2 so to not make every declaration the size of a
3 book, I try to provide a working definition,
4 which I think there's a lot of aspects on
5 gender identity that we could talk about that
6 they're not needed to talk about the definition
7 in the sense that I'm using it in the document.
8 In this document, it's about an adult trans
9 person, so I don't really feel the need to say,
10 well, gee, when she was seven, her gender
11 identity might have been different because
12 that's not at issue here.

13 Q. Would you agree that based on the
14 fluidness of a child's gender identity, it
15 would be impossible for the State of Ohio or
16 anyone to identify the gender identity of a
17 newborn?

18 MS. INGELHART: Objection.

19 THE WITNESS: Again, as I said
20 before, you can make an educated guess, and
21 that educated guess might be 99 percent likely
22 to be correct.

23 Q. But it would just be a guess?

24 A. An educated guess. A guess is
25 flipping a coin, so you can say based on the

1 information I have about this child in front of
2 me, 99 percent chance this child is going to
3 identify as male or female as an adult.

4 Q. Is gender identity hardwired when
5 someone is a child?

6 MS. INGELHART: Objection. Vague.
7 You can answer.

8 THE WITNESS: Kids can be very
9 fluid about a number of different aspects of
10 their identity. This is one of them. In some
11 children, even preadolescence, it's really
12 obvious this kid's gender identity is male or
13 female. In some kids, they may identify as
14 both or different at different times. So in
15 the majority of children, you could say, yes,
16 this kid identifies as male now, 99 percent
17 chance, ten years from now when they're 18,
18 they identify as male, but there are some kids,
19 and they're a minority, that their gender
20 identity, again, is fluid in preadolescence.

21 Q. So in those cases, gender identity
22 is not hardwired?

23 A. No, it's hardwired, it's just
24 developing.

25 Q. So it's hardwired, but changing?

1 A. So, for example, a child who is
2 transgender with or without an intersex
3 condition, they're -- with or without a
4 detectable intersex condition, their gender
5 identity is influenced by their genetics, their
6 prenatal environment, and those are things that
7 we know affect that. And so the things that
8 push people towards one identity or another is
9 relatively fixed because if a kid has an
10 intersex condition, like, for example, five
11 alpha reductase inhibitor deficiency, it's
12 about 60/40 do they identify as male or female
13 in adulthood. And so you can say this kid has
14 five alpha reductase inhibitor deficiency and
15 they may identify as male or female in
16 adulthood, and right now, the child might not
17 have figured that out, might not have gone
18 through the developmental stages necessary for
19 that to be a certain thing. So the -- the
20 things that affect gender identity are fixed,
21 some of them are. The things that -- or -- but
22 the child's ultimate gender identity may not be
23 fixed.

24 Q. The internal sense of their gender
25 is hardwired?

1 MS. INGELHART: Objection.

2 Misstates and mischaracterizes. You can
3 answer.

4 THE WITNESS: Let me give you
5 another example. So there are genes that
6 determine height, and so -- and there's some of
7 these that we know. And so you can say this
8 child is born with genes that will very likely
9 make them quite tall, but if that kid, during
10 childhood and adolescence, has nutritional
11 problems, they may not become tall, they may be
12 quite short as an adult, right, but it doesn't
13 mean you can't say there are things that are
14 hardwired that are going to affect this child's
15 height in adulthood. It's just you can't
16 predict that on a two year old 'cause you can't
17 say, gee, this two year old is going to develop
18 short gut syndrome and be chronically
19 malnourished so they're going to be short
20 anyway. Even though they have the
21 predisposition to be tall, they're going to end
22 up short.

23 Q. Which genes indicate a person's
24 gender identity?

25 A. There's a lot of different genetic

1 aberrations that can affect that. For example,
2 five alpha reductase deficiency. There's a
3 number of genes that form the group of
4 diagnoses of congenital renal hyperplasia,
5 complete androgen sensitivity syndrome, that's
6 the androgen receptor. There are a lot of
7 different things that can influence this from a
8 genetic perspective. I think I also cited a
9 few papers that talked about this gene is more
10 common in trans patients, though we don't know
11 everything.

12 Q. Those are all DSDs that you just
13 talked about, the five alpha, the androgen
14 insensitivities, right? You would all qualify
15 those as DSDs, correct?

16 A. Those patients can have DSDs and be
17 transgender, and I have had transgender
18 patients with those diagnoses. They're not
19 mutually exclusive.

20 Q. I understand that. But I asked you
21 whether or not there were genes that determined
22 someone's gender identity, and I think you just
23 gave me a list of several DSDs, right?

24 A. Genes that can affect people's
25 gender identity.

1 Q. Okay. But those were all DSDs,
2 correct?

3 A. The ones that I gave you examples
4 of, yes.

5 Q. So there are transgender people
6 that have DSDs, right?

7 A. And more commonly than people
8 without DSDs who are trans, yes.

9 Q. And there are folks that have DSDs
10 that aren't transgender, right?

11 A. Correct.

12 Q. And then there are transgendered
13 folks that do not have DSDs, right?

14 A. Yes, but it's probably the case
15 that there's a certain percentage that have
16 DSDs we're just not aware of.

17 Q. Okay. But you would agree that
18 there are people without DSDs that are
19 transgendered?

20 A. Correct.

21 Q. So those DSDs, while they may, at
22 least in your opinion, influence someone's
23 likelihood or not to be transgendered, they
24 aren't determinative of their status of a
25 transgendered person, correct?

1 MS. INGELHART: Objection. Vague.
2 You can answer.

3 THE WITNESS: The thing that
4 determines whether or not somebody's
5 transgender is their gender identity, which you
6 can't figure that out with a blood test.

7 Q. There's no genetic test that would
8 say, aha, that person is going to be
9 transgendered?

10 A. There are genetic tests that can
11 tell you about somebody's gender identity as an
12 adult -- or tell you the likelihood of certain
13 gender identity as an adult, but whether that
14 person identifies as transgender is not
15 something you could tell from a genetic test.

16 Q. Would you agree that an
17 individual's internal sense of their gender is
18 not hardwired when they are seven, six, five, a
19 young child?

20 MS. INGELHART: Objection. Vague.
21 You can answer.

22 THE WITNESS: I don't think
23 that's -- again, it's what we talked about.
24 Those things that influence your gender
25 identity, known and unknown that medicine

1 understands and that medicine doesn't
2 understand, are present and the die is cast in
3 seven year olds.

4 Q. I'm talking about the internal
5 sense, though, just that one specific internal
6 sense of your gender, is that hardwired as a
7 preadolescent, prepubescent young child?

8 MS. INGELHART: Objection. Vague.
9 You can answer.

10 THE WITNESS: All of the things
11 that we're talking about, gender identity,
12 internal sense of one's self, they're
13 biologically based in the same way that
14 depression or anxiety is biologically based.
15 It may be a mental health symptom, but it's
16 because of the squishy organ between your ears
17 that you experience that. Medicine's
18 understanding of that is not always complete,
19 but what we do understand is that there are
20 things that will tend to make somebody
21 transgender. We may not be able to identify
22 the exact gene, but, for example, in twin
23 studies, we know that identical twins who share
24 the same prenatal environment and postnatal
25 environment are more likely to be concordant

1 about whether or not they're trans than
2 fraternal twins who share the same prenatal
3 environment, postnatal environment, but they're
4 no more genetically similar than siblings. So
5 you can say yeah, there's something there and
6 it's something in the genes because that's the
7 only real difference between identical and
8 fraternal twins, but I can't point to a
9 specific gene on a specific chromosome that
10 does that.

11 Q. So your statement that young
12 children are hardwired and that gender identity
13 is biologically based, is that solely based on
14 the twins study?

15 MS. INGELHART: Objection.
16 Compound and vague. You can answer.

17 THE WITNESS: There are a number of
18 studies that I cited, the between study being
19 one of them, Dr. Diamond's twin study, that
20 indicate a genetic component to predisposition
21 to being transgender, but it's not a definite,
22 100 percent thing, and that's the case with a
23 lot of genes. I was talking about height. You
24 can have all the genes predisposing you to be
25 tall, but if you don't get enough nutrition in

1 early childhood, you're not going to be tall.
2 So there are things that influence gender
3 identity in adulthood that are present and
4 fixed in preadolescence, but the manifestation
5 of that, we're not certain of that. Just like
6 the kids who has the genes to be tall, we're
7 not certain they're going to be tall until they
8 get to a certain height. We're not certain
9 this kid identifies as a transgender person in
10 adulthood until they get to a certain point in
11 adolescence. But that doesn't change the fact
12 that you know that there are things that
13 predispose to that, to being tall, to being
14 transgender, that are present from
15 fertilization.

16 Q. So is it fair to say that, in your
17 opinion, gender identity -- sorry, the
18 predisposition towards a gender identity is
19 biologically based, but not necessarily
20 determinative of someone's gender identity?

21 MS. INGELHART: Objection.
22 Compound. Vague. You can answer.

23 THE WITNESS: It's even more
24 complicated than that. There are some things
25 that are -- that have a great deal of influence

1 and some things that have a lesser influence,
2 and so how much or how likely someone is to be
3 of a male gender identity or a female gender
4 identity in adulthood, you can tell with
5 varying degrees of certainty, but nothing is
6 absolute.

7 Q. Nothing with regards to gender
8 identity is absolute?

9 A. As far as the development of gender
10 identity throughout childhood and adolescence.

11 Q. What are some of the things that
12 have a great deal of influence on a person's
13 gender identity?

14 MS. INGELHART: Objection. Vague.
15 You can answer.

16 THE WITNESS: Some of the things I
17 already mentioned, certain DSDs like complete
18 androgen insensitivity syndrome. They almost
19 universally identify as women as adults.

20 Q. Anything else?

21 A. The more severe forms of adrenal --
22 congenital adrenal hyperplasia have a much
23 greater likelihood of identifying male as
24 adults.

25 Q. That's another type of DSD?

1 A. Yes. If you show me a child that
2 is seven that has had a fixed, unwavering
3 gender identity since they were two, I could
4 say with pretty good certainty it's not going
5 to change much. The children without that just
6 absolute I'm a boy, I'm a girl in every aspect
7 of their life, they've never come away from
8 that, the ones who aren't quite that adamant
9 about it, that's more iffy.

10 Q. Does your karyotype have a great
11 deal of influence on your gender identity?

12 A. Having a Y chromosome that is
13 not -- or sorry. Having an XY chromosome
14 without the present of DSDs is pretty
15 predictive of a male gender identity in
16 adulthood, like 99 percent. Having two X
17 chromosomes without a known DSD is pretty
18 predictive about 99 percent or more of being --
19 having female gender identity in adulthood.

20 Q. External genitalia, does that have
21 a great deal of influence on gender identity?

22 MS. INGELHART: Objection. Vague.
23 You can answer.

24 THE WITNESS: We actually know from
25 studies where they've had XY children who were

1 born without an apparent DSD who had either a
2 circumcision mishap or another disorder that
3 caused their penis not to develop, previously,
4 for many years, they would say, well, let's
5 raise this child as a girl and create -- do a
6 vaginal plasty, create a vagina for her, and a
7 lot of those kids didn't identify as female in
8 adulthood. So if it's the case that you have a
9 baby that has typical male genitalia without
10 the presence of a known DSD, most likely,
11 that's a person who's going to identify as male
12 in adulthood. But if you take that kid's
13 genitalia and, for some reason, change it,
14 that's not going to make them change their
15 gender identity. So the presence of genitals
16 can be a clue, but it's not like that changes
17 your gender identity one way or the other.

18 Q. The same would be for a child with
19 intersex conditions, does that have a great
20 deal of influence on their gender identity?

21 MS. INGELHART: Objection. Vague.

22 THE WITNESS: Depends on the
23 intersex condition.

24 Q. Okay. So which intersex conditions
25 have a great deal of influence on gender

1 identity?

2 MS. INGELHART: Objection. Vague.

3 THE WITNESS: An example I've
4 already given was complete androgen
5 insensitivity syndrome. That's basically the
6 androgen receptor doesn't work. So you can
7 have all the testosterone in the world, and
8 that doesn't set off the changes in the cell
9 that testosterone usually does, and those
10 children almost universally identify as women
11 in adulthood.

12 - - - - -

13 (Thereupon, Deposition Exhibit 22,
14 Declaration, was marked for purposes
15 of identification.)

16 - - - - -

17 Q. Just handed you what's been marked
18 as Defendants' 22, which is a copy of a
19 declaration you gave in the case Corbitt V.
20 Taylor. Do you see that?

21 A. I do.

22 Q. And does this appear to be a true
23 and accurate copy?

24 A. Same thing. I haven't read it, but
25 I'm assuming you gave me the correct thing.

1 Q. Turn to Paragraph 11, which is on
2 Page 4 of the document. It says: Gender
3 identity is the internal sense of one's self as
4 male, female or somewhere along the spectrum
5 between the two, or as in the case of agender
6 individuals, external to this spectrum. It
7 should be noted that gender identity being a
8 product of the central nervous system should be
9 considered one of the characteristics when
10 describing the sex of an individual.

11 Do you see that?

12 A. I do.

13 Q. Somewhat more of an expounded upon
14 definition of gender identity than the other
15 definitions we looked at?

16 MS. INGELHART: Objection.
17 Misstates and mischaracterizes prior testimony.
18 Vague. You can answer.

19 THE WITNESS: Again, like I said,
20 it's a complex idea, and so depending on how I
21 use it in a particular report, I may go into
22 more detail or not, though they're all -- all
23 of the ones we've talked about are true and I
24 agree with them.

25 Q. This one, the one we just looked at

1 in the Corbitt declaration in Paragraph 11,
2 Defendants' Exhibit 22 specifically calls out
3 that spectrum concept that we talked about
4 earlier, right?

5 A. Yes.

6 Q. Is it your understanding that
7 Dr. Meter's opinions focuses on the distinction
8 between sex and gender?

9 MS. INGELHART: Objection. Vague.
10 You can answer.

11 THE WITNESS: I think he has an
12 understanding of sex and gender that is far
13 from mainstream.

14 Q. So you don't know if he
15 distinguishes between sex and gender in his
16 expert report?

17 A. I can't remember precisely. If you
18 want me to take time to read through it, I can.

19 Q. So if you turn to Van Meter's
20 report, which is Defendants' Exhibit 18, and if
21 you turn to Page 4 of the report, look at
22 Paragraph 21. Just above that paragraph,
23 there's a heading which says: Gender identity
24 is distinct from biological sex.

25 Do you see that?

1 A. I do.

2 Q. And then it goes on in Paragraph 21
3 to define gender, and he says: It is a term
4 that refers to the psychological and cultural
5 characteristics that have been traditionally
6 associated with biological sex. It is a
7 psychological concept and sociological term,
8 not biological like sex.

9 Do you see that?

10 A. I do.

11 Q. So after reading that caption and
12 that sentence from that paragraph, do you now
13 understand that Dr. Van Meter reaches a
14 conclusion about the distinction between sex
15 and gender?

16 MS. INGELHART: Objection. You can
17 answer. Calls for possibly expert testimony,
18 speaking to another expert's opinion. You can
19 answer, if you can.

20 THE WITNESS: I'm not -- are you
21 talking about gender or gender identity?

22 Q. I'm talking about gender.

23 A. So I think he uses "gender" in a
24 way that makes it clear that he thinks it has
25 nothing to do with sex, and I think that's not

1 right.

2 Q. Yeah. I -- I'm not asking what
3 your opinion is on that, I'm merely asking you
4 whether you recognize that Dr. Van Meter
5 reached a -- an opinion or opined on the
6 difference or distinction between gender and
7 sex. I'm not asking you whether you agree with
8 that, I'm simply asking whether or not you
9 recognize there is such a distinction?

10 A. Between gender and sex, yeah.

11 Q. Okay. You don't explicitly define
12 "sex" in your expert report, correct?

13 MS. INGELHART: Objection.

14 THE WITNESS: Do you mean give a
15 definition of it?

16 Q. That's right.

17 A. I think my expert report makes it
18 clear what I think sex is.

19 Q. All right.

20 A. But I'm not sure I put a definition
21 at the beginning. I could be wrong.

22 Q. You've got a terminology section,
23 right, if you look back at your report,
24 Defendants' Exhibit 19?

25 A. Okay.

1 Q. All right. And you define gender
2 dysphoria in Paragraph 12, right?

3 A. Correct.

4 Q. Gender identity disorder in
5 Paragraph 13?

6 A. Correct.

7 Q. And you say that's now referred to
8 as gender dysphoria, right?

9 A. Yes.

10 Q. And gender identity in 14, right?

11 A. Yes.

12 Q. No other terms which you've
13 explicitly defined; is that accurate?

14 MS. INGELHART: Objection.
15 Misstates and mischaracterizes testimony.
16 Answer.

17 THE WITNESS: I explained later on
18 what I think sex is.

19 Q. Okay.

20 A. So I think I kind of did give you
21 my definition in the body of the work.

22 Q. Why didn't you explicitly define
23 "sex" in your expert report and terminology
24 section?

25 MS. INGELHART: Objection.

1 Misstates and mischaracterizes testimony in the
2 report. You can answer.

3 MR. BLAKE: I'll withdraw the
4 question.

5 Q. Did you explicitly define "sex" in
6 the terminology section of your report?

7 A. In the terminology section?

8 Q. Correct.

9 A. No.

10 Q. Okay. So why did you not
11 explicitly define "sex" in the terminology
12 section of your report?

13 A. Because when I was using "sex" in
14 my report, I was talking about a very complex
15 idea, and I felt it would be more appropriate
16 to just spend time in the report explaining
17 what that was rather than trying to give a
18 short definition, as we discussed before. My
19 definitions are sometimes very short, sometimes
20 more detailed, but in this case, "sex" is such
21 an important thing, I wrote more about it in my
22 actual report.

23 Q. Would it have been possible to give
24 a short definition of the term "sex" in your
25 terminology section?

1 A. Sure.

2 Q. Why -- and you didn't, though,
3 because you thought it was just too complicated
4 for this subject matter or --

5 A. Honestly, I wrote the report and
6 then I read through it and I said what should I
7 give some quickie definitions for, and that's
8 how I picked the ones that were in there.

9 Q. What is your definition of sex?

10 A. Sex is the combination of multiple
11 biologic characteristics of -- since we're
12 talking about people, of humans that usually
13 places people into one of male or female
14 groups, but there are some people, for example,
15 transgender people and people with DSDs who
16 don't fall exactly into those two boxes at the
17 end based on the fact that one aspect is not
18 congruent with the other aspects.

19 Q. Is sex binary or a spectrum?

20 A. I don't think it's binary.
21 Spectrum's one way to describe it.

22 Q. You have described it that way,
23 right?

24 A. It's a spectrum, but not a bell
25 curve.

1 Q. Okay. I mean, in Paragraph 20 of
2 your report, you say: Sex is the biological
3 characteristics of an individual or organism
4 that place it along a spectrum or in discrete
5 categories, including male or female. Right?

6 A. Right.

7 Q. So it's a spectrum on the one hand
8 or it's in a discrete category, including male
9 or female, right?

10 MS. INGELHART: Objection. Asked
11 and answered.

12 THE WITNESS: There are two
13 discrete categories in humans, male or female,
14 into which 99 percent of people fit, and then
15 there's a spectrum between those two in which a
16 much smaller number of people exist.

17 Q. So for the overwhelming majority of
18 people, it is binary, male or female?

19 A. For the majority. I wouldn't say
20 overwhelming.

21 Q. Ninety-nine percent isn't
22 overwhelming to you?

23 MS. INGELHART: Objection.

24 THE WITNESS: No.

25 Q. Would you say gender is more or

1 less binary than sex?

2 MS. INGELHART: Objection. Vague.
3 You can answer.

4 THE WITNESS: It's kind of apples
5 and oranges, but I would say they're about the
6 same.

7 Q. Okay.

8 MS. INGELHART: Can we take a short
9 break?

10 MR. BLAKE: We haven't been going
11 an hour, but we can take a very short break.
12 We've only been going about 45 minutes, but
13 yes, we can take a very short break.

14 (Recess taken.)

15 Q. So just to recap, we were talking
16 about sex, male or female, for the majority of
17 people being a binary classification, right?

18 A. The majority of people fit into the
19 male or female bucket.

20 Q. One or the other, right?

21 A. Right. But true binary would imply
22 that there's not people in the middle, but most
23 people fit on one of those two.

24 Q. And that -- and you view gender as
25 neither more nor less binary than sex; is that

1 accurate?

2 A. I think it is still the case that
3 with gender, the same majority of people who
4 fit into the two categories of male or female
5 as far as sex also fit into the two categories,
6 male or female, as far as gender. I think --
7 so the number of people who fit on those two
8 ends is not significantly different. I think
9 there's a little more -- there's a little more
10 expression of gender with regards to being in
11 the middle.

12 Q. Variation?

13 MS. INGELHART: Objection. Vague.

14 THE WITNESS: There's the same
15 amount of variation, but people sometimes may
16 express it more.

17 Q. Go ahead. I've passed you a
18 document which was previously marked as
19 Defendants' 12. And these are the standards of
20 care, the most recent edition of the standard
21 of care published by the WPATH. I'm sure
22 you're familiar with this document, right?

23 A. Yes.

24 Q. If you turn to Page 16, there's a
25 numbered list that starts on Page 15 and

1 carries onto Page 16. And No. 4, the first
2 sentence says: Mental health professionals
3 should not impose a binary gender.

4 Do you agree with that?

5 A. When you're working with
6 transgender clients, yes.

7 Q. Okay. So despite the WPATH's
8 standard of care which warns against imposing a
9 binary view of gender on transgendered
10 individuals, is it your expert opinion that the
11 State of Ohio should nevertheless impose a
12 binary expression of plaintiffs' gender
13 identity on their birth certificates?

14 MS. INGELHART: Objection. Calls
15 for a legal conclusion. Vague. Misstates and
16 mischaracterizes prior testimony.

17 THE WITNESS: And I'm not sure what
18 you're asking.

19 Q. We both agree that the WPATH says
20 that mental health providers shouldn't impose a
21 binary view on gender, right?

22 A. Correct.

23 Q. You testified -- or you, in your
24 expert report, at great length, talked about
25 the harm that occurs to people when they do not

1 have identity documents which match their
2 gender, right?

3 A. Correct.

4 Q. Okay. So the identity document at
5 issue here is a birth certificate, right?

6 A. Correct.

7 Q. The birth certificate can say male
8 or female, right?

9 MS. INGELHART: Objection. Calls
10 for a legal conclusion.

11 THE WITNESS: I think sometimes.

12 MS. INGELHART: Vague. You can
13 answer.

14 THE WITNESS: They don't write a
15 gender at birth if you're not sure if the child
16 has a DSD.

17 Q. Does that apply to any of the
18 plaintiffs here?

19 A. I don't think so, no.

20 Q. So for all intents and purposes of
21 this litigation, plaintiffs are speaking either
22 a male or female designation on their birth
23 certificate, right?

24 A. That's my understanding.

25 Q. Okay. So that's a one or the other

1 designation, a binary designation, right?

2 A. What the plaintiffs are seeking,
3 yes.

4 Q. Okay. And so despite what the
5 WPATH says about -- about not imposing a binary
6 view of a person's gender, you, nonetheless,
7 think that in this case, the State of Ohio
8 should impose that binary view on their birth
9 certificate --

10 MS. INGELHART: Objection.

11 Q. -- related to someone's gender
12 identity?

13 MS. INGELHART: Objection. Calls
14 for a legal conclusion. Misstates prior
15 testimony. Mischaracterizes prior testimony.

16 THE WITNESS: I think the WPATH
17 standards of care here are trying to talk to
18 mental health providers about how to do therapy
19 with clients. That's a lot different than an
20 agency that is giving identity documents to
21 people, right. There are a lot of trans people
22 who may identify as somewhere along that
23 spectrum, but maybe closer to male, so it would
24 be good for them to have "M" on their ID.

25 Q. So at least that part of the

1 standard of care you don't think necessarily
2 applies to the birth certificates at issue
3 here?

4 MS. INGELHART: Objection.
5 Misstates prior testimony. Mischaracterizes
6 prior testimony. Calls for a legal conclusion.
7 Asked and answered.

8 THE WITNESS: I think the WPATH
9 standards of care here are talking about how
10 you treat people in therapy, and so that's
11 different from how people are treated in
12 society and how they get identity documents
13 issued to them. I think the WPATH here is not
14 speaking to agencies who provide identity
15 documents, they're talking to therapists.

16 Q. So that's a "yes"?

17 MS. INGELHART: Objection. Asked
18 and answered. Misstates prior testimony.
19 Mischaracterizes prior testimony. Calls for a
20 legal conclusion. You can answer.

21 THE WITNESS: I don't think they're
22 the same thing. So saying to a therapist that
23 if your client identifies somewhere on the
24 spectrum between male or female, don't try to
25 say to them you have to pick man or woman is

1 very different from saying to the patient, gee,
2 you have a more masculine gender identity and
3 expression. What would be the safest and best
4 thing for you to have on your identity
5 documents? So I think it is possible for a
6 health care provider to both support a patient
7 transitioning a binary option on an identity
8 document while also understanding that that
9 patient's gender identity may not fit exactly
10 in those -- those boxes.

11 Q. Have you ever looked at an Ohio
12 birth certificate before?

13 A. Not that I know of.

14 Q. This was previously marked as
15 Defendants' Exhibit 1. It is the birth
16 certificate for one of the plaintiffs in this
17 matter. The word "gender" doesn't appear on
18 the birth certificate, right?

19 A. Not that I can see, no.

20 Q. It states "sex," right?

21 A. Correct.

22 Q. This particular one states male,
23 right?

24 A. Correct.

25 Q. As a medical provider, do you

1 understand the value of recording an
2 individual's sex at the time of their birth?

3 MS. INGELHART: Objection. Vague.
4 Calls for a legal conclusion. You can answer.

5 THE WITNESS: I understand that the
6 state may want statistics about that, but I
7 don't see the value beyond statistical analysis
8 and providing -- otherwise, the whole birth
9 certificate providing evidence that this person
10 was born and they're a citizen.

11 Q. Well, like, for example, the
12 statistical information regarding growth charts
13 for infants is one way in which knowing a
14 child's sex is relevant, right?

15 A. Yeah, but...

16 MS. INGELHART: Objection. Calls
17 for a legal conclusion and vague. You can --
18 or not legal conclusion. Objection. Vague.
19 You can answer.

20 THE WITNESS: Yeah, but
21 pediatricians don't have a child walk into
22 their office and say can you show me little
23 Billy's birth certificate so I can make sure
24 I'm using the right growth chart? They look at
25 the kid and they talk to the parents and they

1 get a history, and that's what informs it.

2 Q. How is the information communicated
3 to the organizations that create the growth
4 charts, do you know?

5 A. I'm not sure what you're asking.

6 Q. How are the growth charts formed,
7 do you know?

8 A. They've done studies on a bunch of
9 kids and they follow them throughout childhood
10 and say 95 percent of kids fall within this
11 length and weight, and they're from research
12 studies.

13 Q. And who compiles that, do you know?

14 A. They're kind of sort of -- it's old
15 data. I mean, they haven't changed that much.
16 The one thing that does happen is there are
17 growth charts specific to certain kids, so you
18 could get growth charts specific to kids with
19 certain illnesses. But, I mean, it's been the
20 same for a long time and it's just you studied
21 kids and saw they grew this much by this age
22 and you average it together. It's not
23 something that changes often. And I don't
24 think there's an agency that comes up with
25 those, I think they're published in journals.

1 Q. To your knowledge?

2 A. Yes, to my knowledge.

3 Q. You're not a pediatrician, right?

4 A. No.

5 Q. When a person is born, do you have
6 a general understanding of how the sex of that
7 individual is determined?

8 A. Generally, yeah.

9 Q. And what is that?

10 A. The pediatrician or family practice
11 doctor caring for the infant or sometimes the
12 obstetrician or midwife attending the delivery
13 does a relatively cursory examination of the
14 child's genitals and says it's a boy or it's a
15 girl or these genitals are atypical. We need
16 more information.

17 Q. Should -- in your opinion, should
18 the medical provider perform the more detailed
19 examination of the genitals at the time of
20 birth?

21 A. It's warranted if there are clues
22 that this might not be normal.

23 Q. And do you have any understanding
24 of whether or not a more detailed examination
25 is conducted if there are circumstances which

1 warrant such an examination?

2 A. Yeah. Generally, kids who have a
3 typical genitals undergo a -- an evaluation.

4 Q. A more thorough evaluation?

5 A. A more thorough evaluation.

6 Q. If a medical provider is providing
7 the right level of care, right?

8 A. Medical or nursing provider.

9 Q. And you use the word " cursory " like
10 it's somehow insufficient to determine the sex
11 of a child, but, I mean, you don't think that
12 the check or examination of a child at the time
13 of birth is in any way insufficient, do you?

14 MS. INGELHART: Objection.
15 Misstates prior testimony. Mischaracterizes
16 and is also compound.

17 THE WITNESS: I think people look
18 at a child's genitals and say male, female or I
19 don't know, and that's something that happens
20 really quick. You look at it. If it looks
21 like a penis and a scrotum with two descended
22 testicles, okay. That's it. That takes a
23 second or two.

24 Q. Is that insufficient?

25 MS. INGELHART: Objection. You can

1 answer.

2 THE WITNESS: It is sometimes
3 incorrect.

4 Q. How often is it incorrect, do you
5 know?

6 A. So in the case of transgender
7 people, I think that incidents is probably
8 somewhere in the one in 200 to one in 500
9 range.

10 Q. So what do you mean in the case of
11 a transgendered person? What do you mean by
12 that?

13 A. So most transgender people have a
14 gender identity that is different from their
15 sex assigned at birth, and so in most cases,
16 for transgender people, that assignment at
17 birth is incorrect.

18 Q. But it's not your testimony that
19 the doctor misidentified the genitalia at birth
20 for transgendered people, correct?

21 MS. INGELHART: Objection.
22 Misstates --

23 MR. BLAKE: That's why I'm asking
24 for the clarification.

25 Q. That's not you're testimony, is it?

1 A. It is that the doctor does not have
2 enough information at birth to 100 percent or
3 to make that determination with a hundred
4 percent accuracy.

5 Q. What is that determination?

6 A. The sex of the individual, of the
7 child.

8 Q. So they've -- you don't -- so I
9 guess I want to -- I want to back up.

10 How often does a medical provider
11 misidentify the external genitalia at the time
12 of birth?

13 A. If you add up all of the intersex
14 conditions, the children with DSDs that may not
15 be identified at birth, which is a lot of them,
16 and those people who are transgender, half a
17 percent.

18 Q. Transgendered people don't have
19 misidentified genitalia --

20 MS. INGELHART: Objection. Vague.

21 Q. -- right?

22 A. No. They have an incorrectly
23 listed sex on this birth certificate.

24 Q. So I'm not asking you about the --
25 what you're calling an incorrectly identified

1 sex, I'm asking you: During this what you've
2 termed a cursory examination of the newborn's
3 external genitalia, how many times do the
4 doctors get it wrong?

5 MS. INGELHART: Objection. Vague.

6 THE WITNESS: So what is the
7 doctor -- when they look at the genitalia --

8 Q. That's right.

9 A. -- determining?

10 Q. That's right.

11 A. I'm asking for clarification.

12 Q. Okay.

13 A. So if the question is how accurate
14 is a doctor looking at the genitalia
15 determining the sex --

16 Q. That's right.

17 A. -- or determining what the
18 genitalia looked like?

19 Q. The latter one.

20 A. Okay. A doctor can say that looks
21 like male genitalia, female genitalia or
22 ambiguous.

23 Q. And how often do they get that
24 incorrect?

25 A. Be definition, if you're talking

1 about how something looks, they wouldn't.

2 Q. That almost never happens, right?

3 A. No. There are cases where people's
4 sex is incorrectly put on their birth
5 certificate, typo.

6 Q. But as a -- so it's a typographical
7 error?

8 A. On the part of the person filling
9 it out.

10 Q. Okay.

11 A. Who is the one who looked at the
12 genitals.

13 Q. But you don't have any, like, stats
14 or percentages based on what you know, you
15 know, how these doctors misidentify the
16 genitalia when they're doing this examination
17 at birth, right?

18 A. Misidentify -- actually, a better
19 way to say this is the doctor, when they
20 identify the child at birth, looks and sees is
21 there a penis or is there a clitoris, is there
22 a scrotum or are there labia. And being able
23 to say those look like labia, that looks like a
24 scrotum, that looks like a clitoris, that looks
25 like a penis, there's probably, occasionally,

1 and I can't tell you the number, the person is
2 tired, they write the gender marker down
3 incorrectly. But if you're asking sex, that's
4 different than is there a penis or a clitoris
5 present. I think penis or clitoris, you can
6 say that that's almost always correctly
7 identified.

8 Q. And like you said before, it's not
9 possible to identify the gender identity of a
10 newborn at the time of birth, right?

11 A. Again, you can make an assessment
12 that is going to be correct 99 percent of the
13 time, but is not going to be absolutely
14 correct.

15 Q. Yeah. There's -- there is, in
16 fact, no way to correctly, a hundred percent of
17 the time, identify the gender identity of a
18 newborn at the time of birth, right?

19 A. A hundred percent of the time, no.

20 Q. Okay. 'Cause the only way that you
21 can truly determine a person's gender identity
22 is by talking to them, right?

23 A. By evaluating them, yes.

24 Q. And if you found a person
25 unconscious, there aren't any medical

1 procedures or evaluations you could perform to
2 determine the gender identity of that
3 unconscious person, right?

4 MS. INGELHART: Objection. You can
5 answer.

6 THE WITNESS: I could look at their
7 medical history and their record.

8 Q. Well, that would reveal that
9 they've maybe undergone some transition, right,
10 through medical intervention or otherwise,
11 right?

12 A. Yes. And if that's the case and
13 you have the notes for the therapist who
14 treated the patient, they assess that, so it's
15 sometimes possible.

16 Q. But even then, it might not -- I
17 mean, I guess, speaking in pure hypotheticals
18 here, but it's possible someone has undergone
19 medical -- you know, medical transition,
20 medical intervention, but are not themselves
21 transgender, right?

22 MS. INGELHART: Objection. Vague.

23 THE WITNESS: That somebody's been
24 diagnosed with gender dysphoria and undergone
25 hormonal and surgical treatment, is that what

1 you're talking about?

2 Q. No, I wasn't, but -- and I didn't
3 realize that that's what you were talking
4 about. So when you talk about looking at
5 someone's medical record, that would include
6 notes from a psychologist that would identify
7 them as having gender dysphoria, for example?

8 A. Sometimes, yes.

9 Q. Okay. So I suppose -- I suppose,
10 you know, not having the benefit of someone's
11 psychological evaluations, if you find them
12 unconscious, there aren't any medical
13 procedures or evaluations you could perform to
14 determine the gender identity of that
15 unconscious person, right?

16 MS. INGELHART: Objection. Vague.

17 THE WITNESS: Let me give you an
18 example from my emergency medicine practice.

19 Q. Okay.

20 A. We have a medical record that
21 actually has a transgender function in it where
22 the patient can identify their preferred
23 pronoun, their preferred name. And I work at a
24 hospital in a university town, and there's
25 a not insignificant population of trans young

1 people that attend the university, and so I've
2 had cases where Friday night, they went out
3 drinking, they were intoxicated, they came in,
4 they were registered based on the driver's
5 license they had in their pocket or their
6 student ID card, and then I saw that
7 information, so sometimes you do.

8 Q. So this is, like, someone who's
9 incapacitated in some way?

10 A. Drunk.

11 Q. Are they able to talk to you?

12 A. Not when they're that drunk that
13 they end up in the ER.

14 Q. So they're incapacitated, you can't
15 ask them, hey, what's your gender, right?

16 A. Correct.

17 Q. You look at their driver's license,
18 and based on their driver's license and, what,
19 something about their physical appearance,
20 you're able to make an inference that they are
21 transgender?

22 MS. INGELHART: Objection.

23 Incomplete hypothetical. You can answer.

24 THE WITNESS: Sometimes it says
25 that in the medical record, so yeah, I'm very

1 certain. There are some cases where I kind of
2 go that's possible. I'm not sure. But I have
3 had cases where I've known that this person was
4 trans, even with a driver's license that may
5 not have been corrected yet.

6 Q. Again, I mean, if you're looking at
7 their medical record that's being communicated
8 by them to their medical record and then
9 through to you at some later time, right?

10 A. It was the observations of treating
11 professionals, but then also in the medical
12 record we use, it is possible for somebody to
13 say I want you to use the pronoun "he/him," or
14 "she/her" and I want you to use this name. So
15 the patient can state it or it can be an
16 observation based on their evaluation.

17 Q. You would agree that there's no
18 tests, medical or psychological, to diagnose
19 transsexualism, right?

20 MS. INGELHART: Objection.

21 THE WITNESS: No.

22 Q. You disagree with that statement?

23 A. Yes, I do.

24 Q. It says in Paragraph 7 of your
25 report that you've evaluated roughly 400

1 transgendered patients since 2005, right?

2 A. Yeah. I actually just had my
3 clinic director run that. It's over 500. I've
4 been using 400 for years.

5 Q. Four hundred, 500, whatever. Let
6 me ask you this: Have you ever evaluated
7 someone who is transgendered whose gender
8 identity later reverted back to their birth
9 sex?

10 A. I have treated a few patients who
11 have detransitioned, but not because their
12 gender identity changed.

13 Q. Okay. Hold on a second.
14 "Detransitioned," that's the term. That's the
15 term -- that's the proper term?

16 A. That's the common term.

17 Q. The common term. Is that the term
18 you used?

19 A. It is.

20 Q. Okay. And detransition, can you
21 tell me what that means?

22 A. So, for example, somebody who's
23 assigned female at birth but has a male gender
24 identity in adulthood or somewhere along the
25 spectrum not female, and they can do any

1 portion of social, medical or surgical
2 transition, and then at some point decide they
3 want to undo that.

4 Q. Okay. Understood.

5 All right. So you have had, as
6 patients, a handful of people that have
7 detransitioned?

8 A. Yes.

9 Q. Okay. And you said -- well, what
10 was -- what were the reasons for that?

11 A. Because it's really hard to be
12 trans in our society.

13 Q. So you attribute their
14 determination to detransition as to social
15 pressure?

16 A. Social trauma and social loss. So
17 you transition and -- and understand, these are
18 actually old cases in my practice. I mean, I
19 don't think I've done that in the last five
20 years. So somebody transitions and their
21 family rejects them, they lose their job, they
22 are perceived as transgender in a lot of social
23 situations, and that brings with it risk of
24 interpersonal violence, risk of being denied
25 services. I mean, it's really hard. And so

1 they decide that it's less painful to go back
2 in the closet.

3 Q. I know that you're not a
4 pediatrician, but are you aware that that
5 detransitioning is more common in children?

6 MS. INGELHART: Objection. Vague
7 and possibly incomplete hypothetical.

8 THE WITNESS: It's not so much
9 detransitioning as it is letting the child
10 express themselves the way they want to, and
11 maybe that is -- you know, so, say, for
12 example, an assigned female at birth child who,
13 preadolescent, wants to present themselves in a
14 more masculine way, maybe wants to adopt a more
15 masculine name, maybe even wants people to use
16 "he" and "him" as the correct pronoun, and then
17 in adolescence, they say, you know, maybe
18 that's not where I am, maybe I'm just a butch
19 young woman. And so that -- it's not -- it's
20 not like you've treated kids with hormones or
21 surgery or done more than -- done more social
22 transition other than letting the kid play on
23 the right soccer team, right. And that can
24 change with time and it's -- it's nothing
25 that's fixed. So the idea of detransitioning

1 isn't a good way to think about it.

2 Q. Among children?

3 A. Among preadolescent children, yes.

4 Q. You would say that that
5 circumstance you just described is more common
6 than the detransitioning among adults?

7 A. Yes, very much so.

8 Q. Okay. And it's also not uncommon
9 for elderly people who have lived their life as
10 one gender to transition much later in life,
11 right?

12 A. I've had a number of elderly
13 patients who've done that.

14 Q. They live a large portion of their
15 life as one gender, and then after decades
16 maybe of marriage, kids, career, et cetera,
17 they determine that their gender identity no
18 longer conforms to their sex, right?

19 MS. INGELHART: Objection. Vague.

20 THE WITNESS: It's not that their
21 gender identity no longer conforms, it's just
22 that when they were a young adult in the '70s,
23 it was really, really, really hard to
24 transition. And so, I mean, there's this idea
25 that people change when the pain of changing is

1 less than the pain of staying the same, and the
2 pain of transition in the 1970s was huge. You
3 had to divorce your spouse. If you had
4 children, some centers required the children to
5 be adults and they had to sign a form that said
6 they were okay with it for you to be able to
7 get care. Society was much less accepting of
8 trans people, and so they may not have had the
9 opportunity. I don't think you'll see that
10 phenomenon 50 years from now when the 20 year
11 olds from today are that age because it's just
12 something that's more available today.

13 Q. So you believe that all of the
14 elderly people who transition are transitioning
15 later in life due to social pressures
16 preventing their transition at an earlier time
17 in their life?

18 MS. INGELHART: Objection.
19 Misstates prior testimony and mischaracterizes
20 it, but you can answer.

21 THE WITNESS: Not just -- yes,
22 social pressure, but not just that,
23 availability of services.

24 Q. It wasn't a medical or -- there was
25 no medical option at the time available to them

1 to transition?

2 MS. INGELHART: Objection.
3 Misstates prior testimony. You can answer.

4 THE WITNESS: In many cases, it was
5 very difficult to come by.

6 Q. Are you aware of any advocacy
7 groups or support groups directed at people who
8 seek to detransition or revert back to their
9 sex assigned at birth?

10 A. I wouldn't be surprised if that
11 existed, but I haven't heard of any.

12 Q. Have you heard of the Detransition
13 Advocacy Network?

14 A. No.

15 Q. Are you aware that that group is
16 there to provide resources and support to
17 transgendered people who have decided not to
18 transition or stop transitioning?

19 A. Like I said, I've never heard of
20 them, so I don't know what they do.

21 Q. Would you contend that gender
22 identity is fixed for those individuals?

23 MS. INGELHART: Objection.
24 Incomplete hypothetical.

25 THE WITNESS: So I haven't

1 evaluated those individuals, but what I can say
2 is in my experience, the few people who I have
3 helped detransition, their gender identity
4 didn't change.

5 Q. If you can take a look at
6 Defendants' 20. And Page 4 of the document,
7 Paragraph 15. If you look at the last
8 sentence, it says: In such a case, the only
9 way to identify the person's true sex is to
10 know the person's gender identity.

11 Do you see that?

12 A. I do.

13 Q. What do you mean by "a person's
14 true sex"?

15 A. The most medically correct sex
16 based on an understanding of all the components
17 that go into determining sex.

18 Q. Is a person's sex as determined by
19 their chromosomes their true sex?

20 MS. INGELHART: Objection.
21 Incomplete hypothetical. Vague.

22 THE WITNESS: The vast majority of
23 people don't know their chromosomal count, I
24 don't know mine, so that's not something you
25 can utilize. It's not something you test in

1 trans people as a matter of course. So if, for
2 some reason, you know that, yeah, that can go
3 into it, but that's not something that you know
4 in the vast majority of cases.

5 Q. So a true -- a person's true sex,
6 in your mind, relates to their own
7 self-awareness of their gender; is that
8 accurate?

9 A. I think the most important
10 characteristic in determining sex from a
11 clinical and biological perspective is the
12 person's gender identity, which is a function
13 of their central nervous system.

14 Q. And a person's chromosomes do not
15 factor into what you call their true sex?

16 MS. INGELHART: Objection.
17 Misstates and mischaracterizes prior testimony.

18 THE WITNESS: That can influence
19 it, but that's not as important. And like I
20 said, in the vast majority of cases, you don't
21 even know that.

22 Q. What about a person's natural
23 hormone levels, does that determine their true
24 sex?

25 MS. INGELHART: Objection. Vague.

1 THE WITNESS: It is one of many
2 characteristics that may go into that. When
3 they are checked pre-transition, in my
4 experience, there's actually a significant
5 portion of trans patients who don't have normal
6 hormone levels before you treat them at all, so
7 if you know that, it can be something to
8 consider.

9 Q. Are you aware of any studies that
10 have been conducted that have tested one way or
11 the other a transgendered person's hormone
12 levels pre-transition?

13 A. There's at least one study that I
14 can think of that looked at the frequency of
15 polycystic ovarian syndrome in transgender men,
16 and that's a hyperandrogenic state where you
17 have higher than normal androgen levels, and it
18 was more common amongst trans men, and I
19 noticed that at my own practice. It's more
20 common for trans men to have PCOS than
21 cisgender women than I treat.

22 Q. Do you know when that study was
23 conducted?

24 A. No. It's not super recent.

25 Q. Do you know the sample size you

1 used to conduct that study?

2 A. No.

3 Q. Do you know how the sample size was
4 selected?

5 A. Again, I remember there's a study.
6 I can get it for you if you want, but I can't
7 tell you the details of it.

8 Q. Is the sex determined by a person's
9 external genitalia their true sex?

10 MS. INGELHART: Objection.

11 Incomplete hypothetical. You can answer.

12 THE WITNESS: In the sense of what
13 is entered on their birth certificate based on
14 their external genitalia, that's right most of
15 the time.

16 Q. Is the sex determined by a person's
17 internal reproductive organs their true sex?

18 MS. INGELHART: Incomplete
19 hypothetical. You can answer.

20 THE WITNESS: That's a even less
21 frequently assessed thing, and so, again, while
22 it can influence it, it's not the biggest
23 thing.

24 Q. So in your expert opinion, the
25 critical component of a person's true sex is

1 their gender identity, right?

2 MS. INGELHART: Objection. Vague.
3 You can answer.

4 THE WITNESS: I think that's the
5 most important one, but I think also sometimes
6 in investigating patients, you may actually not
7 change their gender identity, but change their
8 understanding of themselves. So I've had
9 patients who presented to me as trans that I
10 diagnosed with an intersex condition that they
11 previously hadn't been diagnosed with, and it
12 doesn't make them not trans, it doesn't change
13 their gender identity, but it may make them
14 subsequently identify as somebody with a DSD.

15 Q. What scientific basis do you have
16 to support your opinion that a person's true
17 sex is determined in the brain by their gender
18 identity?

19 A. The most important organ in the
20 body is the brain. In fact, that's how we
21 determine whether or not you can be an organ
22 donor. If your brain is dead, but every other
23 organ is functioning normally, we take those
24 organs, if you're an organ donor, and give them
25 to other people. And gender identity is a

1 function of the brain. It's what makes you --
2 you know, the brain is what makes you the
3 person that you are, and given that, the --
4 essentially, the sex or the gender of the brain
5 should be given the greatest importance.

6 Q. What scientific basis do you have
7 to state that the brain is what determines
8 someone's gender identity?

9 MS. INGELHART: Objection.
10 Misstates and mischaracterize testimony. You
11 can answer.

12 THE WITNESS: That's what organized
13 medicine does. When trans people come in and
14 they say my gender identity is female, we don't
15 offer them reparative therapy to change that,
16 we offer them therapy to change their body to
17 match their internal sense of self.

18 Q. So is there a study that has
19 indicated that the brain or the part of the
20 brain that is causing someone to take on a
21 gender identity?

22 A. There are a few, like, functional
23 MRI studies that suggest difference in the
24 brain of transgender people that more closely
25 approximates what one would expect based on

1 what their gender identity is, but the science
2 in this is super early, you know. There's not
3 a -- I can't do an MRI on somebody and say your
4 gender identity is male.

5 Q. Have you taken a close look at
6 those functional MRI studies?

7 A. I mean, I've read them. Not
8 recently.

9 Q. Do you know whether those
10 functional MRI studies control for
11 neuroplasticity?

12 A. What do you mean by
13 neuroplasticity?

14 Q. That's going to be my next
15 question. Do you know what neuroplasticity?

16 A. I know what I understand it to
17 mean.

18 Q. What do you understand
19 neuroplasticity to be?

20 A. Much more so in children than in
21 adults, the brain can change. In fact, that's
22 a -- one of the big things throughout childhood
23 development is the brain changes, and that's
24 the reasons that we realize that if kids suffer
25 trauma, it changes the brains, and that can

1 extend on into adulthood and cause later
2 problems. Adults have a much lesser
3 neuroplasticity, and we know some parts of the
4 brain can take on roles they didn't originally
5 have, but it's not really a lot in adults.

6 Q. So do you know whether those
7 functional MRI studies controlled for the
8 neuroplasticity that you just described?

9 A. I don't understand how you're --
10 like, what you mean by that.

11 Q. Well, the functional MRI studies
12 took a look at a number of transgendered
13 individuals pre- -- pre-transition, right?

14 A. I think there are some that looked
15 pre and post and some that just looked post.

16 Q. And then -- right. And I was going
17 to say they also looked at those same
18 individuals post and looked for similarities,
19 right?

20 A. Correct.

21 Q. And to see whether or not certain
22 images from the brain changed or stayed the
23 same, right?

24 A. Correct.

25 Q. And those MRI studies identified an

1 area of the brain which they said, you know,
2 this could relate to someone's gender identity
3 because it was constant throughout the
4 transition process, right?

5 A. Not necessarily because it was
6 constant, but because it more resembled the --
7 what you would expect in people whose sex
8 corresponded with that patient's gender
9 identity.

10 Q. But those studies didn't look at
11 the brains of children, right, to see if the
12 MRI -- the functional MRI test, whether that
13 same image was either present or not present in
14 a child, right?

15 A. That's a totally different
16 question. I mean, the studies didn't ask that.

17 Q. Correct. I agree with that. They
18 didn't look at what the -- what the child brain
19 would be, right?

20 A. Okay. Yes.

21 Q. Let's go to paragraph -- before we
22 do that, "true sex" isn't a medical term,
23 right?

24 A. When I say that, I mean the most
25 accurate sex.

1 Q. Okay. That's not, like, a term
2 that would appear in a textbook you studied in
3 medicine school, for example?

4 A. There are books about treating
5 trans patients that talk about that.

6 Q. Is that a psychological term?

7 A. It is an assessment of a lot of
8 different things that go into -- or there's a
9 lot of different things that go into
10 determining that, but the psychological
11 evaluation is paramount.

12 Q. When you do intake of a patient as
13 an emergency physician, emergency room doctor,
14 I assume one of the data points you collect is
15 their sex, right?

16 A. The sex is in their medical record
17 already. In cases where it is obvious from
18 their medical record or I get the feeling that
19 this might be the case, I may ask them what
20 their -- you know, do they have a preferred
21 pronoun that they want me to use, so inviting
22 the patient to share their gender identity with
23 me.

24 Q. From a treatment perspective when
25 someone comes into the emergency room, does

1 there gender identity ever play a role in the
2 course of treatment that you're going to
3 recommend?

4 A. It can.

5 Q. How can it?

6 A. So let's say they're there for
7 mental health services, they are a college
8 student and they have suicidal ideation. If
9 it's the case that I think they need to be
10 hospitalized when I talk to the accepting
11 hospital, I'm going to say I think this
12 person -- you know, do you have a female bed,
13 not do you have a male bed. And I might, on
14 behalf of the patient, say, look, I think this
15 is a trans person and they would be better
16 suited in this area. Can you produce this or
17 can you -- not produce this, can you provide
18 this to the patient. And if the answer's no, I
19 go to a different facility.

20 Q. Are these procedures that you would
21 perform on a male that you wouldn't perform on
22 a female in an emergency room situation?

23 A. Given that transgender people
24 exist, the answer to that's no because there
25 are some transgender men who are males who

1 might be pregnant, so I might do a pregnancy
2 test on them.

3 Q. You would never do a pregnancy test
4 on a biological male, right?

5 MS. INGELHART: Objection.

6 THE WITNESS: On somebody assigned
7 male at birth who has a penis and testicles,
8 actually, rarely, yes, because there's
9 occasionally testicular tumors that create the
10 same hormone that's tested for in pregnancy, so
11 I have occasionally done that, but not for the
12 reasons that you would typically think.

13 Q. And not in the circumstances where
14 it's important to know whether or not someone's
15 pregnant, for example, right?

16 A. Correct.

17 Q. You would never run a pregnancy
18 test on a transgendered female, would you?

19 MS. INGELHART: Objection.
20 Incomplete hypothetical.

21 THE WITNESS: I've actually done
22 that in error because they didn't share with me
23 that they were trans at the time and then
24 subsequently realize, oh.

25 Q. Had you known, you wouldn't have

1 done it, right?

2 A. Correct. Unless I thought they
3 might have testicular cancer.

4 Q. All right. Now we can do go to
5 Paragraph 32 of your report.

6 A. This is 20, right?

7 Q. Nineteen. There's a lot of reports
8 floating around, but this is the report in this
9 case, Defendants' Exhibit 19. Let me know when
10 you're there. It's on Page 11.

11 A. Paragraph 30?

12 Q. Thirty-two.

13 A. Okay. I'm there.

14 Q. All right. It says: Thus, in
15 addition to the purely scientific mandate that
16 gender identity is the appropriate
17 determinative factor for selecting male or
18 female gender markers on identity documents,
19 there's a clinical imperative that gender
20 identity be used to make that determination.

21 Do you see that?

22 A. I do.

23 Q. What is the purely scientific
24 mandate that you reference in this paragraph?

25 A. That it's scientifically correct,

1 that the most important determinant from a
2 biological perspective of whether someone is
3 male or female is their gender identity.

4 Q. What -- where do you get scientific
5 mandate from? Where does that come from?

6 A. That's the understanding that
7 people who treat trans people have come to.
8 And, like I said, the most important aspect of
9 being a person is your brain because if your
10 brain dies and the rest of you doesn't, we
11 still consider you dead. So your personhood is
12 largely between your ears.

13 Q. So what is the source of the
14 mandate that you reference in Paragraph 32?

15 A. That we understand what the brain
16 is.

17 Q. Okay. So is there -- I mean,
18 that's not how medicine works. You have -- you
19 have things that you learn from either, you
20 know, studies or just over time, right? We
21 know the heart has four chambers, for example.
22 So where do you draw the knowledge that there's
23 a purely scientific mandate out there stating
24 that gender identity is the appropriate
25 determinative factor for selecting male or

1 female gender markers on identity documents?

2 Where do you get that?

3 MS. INGELHART: Objection. Asked
4 and answered.

5 THE WITNESS: Again, that's just
6 sort of -- I mean, we didn't used to know that
7 the brain was the center of your knowledge and
8 understanding and identity. We used to think
9 it was the heart. Now we understand that who
10 you are, what you do, what you choose to do,
11 what is the important -- the most important
12 characteristic of a person is their brain.

13 Q. Are you able to identify a source
14 for this purely scientific mandate as you sit
15 here today?

16 MS. INGELHART: Objection. Asked
17 and answered.

18 THE WITNESS: It -- you want a
19 paper that says we understand the brain is the
20 seed of the intellect and --

21 Q. You stated this in Paragraph 32.
22 You haven't cited anything. And when you say
23 it's purely scientific mandate, it's infers
24 that it comes from somewhere, and I'm just
25 trying to find out where that mandate comes

1 from.

2 A. It's comes from our understanding
3 of your personhood is your brain.

4 Q. Okay. Whose understanding?

5 A. Everybody. UNOS, the United
6 Network for Organ Sharing. They will take your
7 organs if you're brain dead. If you're not
8 brain dead, they're not going to take your
9 organs.

10 Q. So the United Network for Organ
11 Sharing says that gender identity is the
12 appropriate determinative factor for selecting
13 male or female gender markers on identity
14 documents?

15 A. No. They say that your personhood
16 is your brain.

17 Q. Okay. Okay. So not UNOS.

18 Has -- besides you, in Paragraph 32
19 of this report, has anyone else written that
20 the purely scientific mandate that gender
21 identity is the appropriate -- appropriate
22 determinative factor for selecting male or
23 female gender marker on identity documents? Is
24 there anywhere else I can find that?

25 A. There's just some -- there are

1 things that you -- you understand, right. So I
2 understand that something simple, like
3 diabetics have high blood sugar and there are a
4 lot of studies about controlling the blood
5 pressure of diabetics, but it is the assumption
6 and understanding that the thing that makes you
7 have diabetes mellitus is reflected in elevated
8 blood sugar. So there's no source for that,
9 but there's a lot of sources around treatment
10 of diabetes. And, I mean, that's just --

11 Q. So your testimony today is that
12 there's not a medical source out there for
13 people with diabetes have high blood sugar?

14 MS. INGELHART: Objection. Vague.

15 THE WITNESS: This is a common
16 understanding of people who work in transgender
17 medicine. It's not -- it's understood and
18 flows from our understanding that the most
19 important thing about you and the thing that
20 makes you you is your brain. It's not your
21 left arm, it's not your heart, it's not your
22 genitals, it's not any of that, it's your
23 brain, and if your brain has a male gender
24 identity, that's your male sex. And that's the
25 case for transgender people and cisgender

1 people.

2 Q. You would agree that an Ohio birth
3 certificate is an identity document, right?

4 A. Yes.

5 Q. Do you also agree that it is
6 impossible for a medical provider to use gender
7 identity to determine whether to input male or
8 female for sex when a child is born? We
9 discussed that, right?

10 A. I think what I said was that
11 providers, based on evaluating the child, can
12 make a very good guess as to what that's going
13 to be, and 99 percent of the time, they're
14 correct.

15 Q. Right. But what it -- you said
16 what it's going to be, but not what it is at
17 that moment, right?

18 A. You can't assess it at that moment.

19 Q. And in the case of transgendered
20 people, it's not your testimony that it would
21 have been accurate at that moment of birth for
22 the medical provider to say, yes, I see a
23 penis, I see descended testicles, but
24 nevertheless, I'm going to write down "female"
25 on the birth certificate. You don't think that

1 that would have been accurate, right?

2 MS. INGELHART: Objection. Vague.

3 THE WITNESS: I don't think that
4 would be the right thing to do, given 99
5 percent chance it's going to be male, smaller
6 chance it's going to be female.

7 Q. So when does the sex identifier on
8 a transgendered birth certificate become
9 inaccurate?

10 A. Late adolescence, if it is
11 incorrect. If you have a cisgender child who's
12 an identified male as birth and they identify
13 at 16 that they're male, then you know it's
14 accurate. If you have somebody who's assigned
15 male at birth and by the time they're 16, their
16 gender identity is female, you know it was
17 inaccurate.

18 Q. No way to determine whether a
19 person's transgender at the time of birth,
20 right?

21 A. No.

22 Q. All right. Let's go to
23 Paragraph 21 of your report, Defendants'
24 Exhibit 19. It's on Page 7. Let me know when
25 you're there.

1 A. I'm there.

2 Q. All right. In this paragraph, you
3 identify several biological components that
4 comprise a person's sex, right?

5 A. Correct.

6 Q. All right. You identified the sex
7 chromosomal type. That's the XX and XY
8 karyotyping that we've been discussing today,
9 right?

10 A. Correct.

11 Q. The SRY gene, right? That's
12 another one that you identify, right?

13 A. Correct.

14 Q. Hormonal -- a mix of the hormones
15 and the accompanying sex characteristics,
16 right?

17 A. Correct.

18 Q. Size of the gametes, that's another
19 one?

20 A. Yes.

21 Q. Gender identity, right?

22 A. Yes.

23 Q. And then gonad type, right?

24 A. Correct.

25 Q. Okay. Aside from the brain studies

1 that we talked about, the functional MRI
2 studies, do you have any other scientific basis
3 for your contention that gender identity is
4 biological?

5 MS. INGELHART: Objection. Asked
6 and answered. You can answer.

7 THE WITNESS: There were some other
8 studies I cited about gene mutations that are
9 more common amongst trans people. There's the
10 twin study that I mentioned earlier where
11 identical twins are much more likely to be
12 concordant for being transgender than fraternal
13 twins.

14 Q. Anything else?

15 A. There was the one study that I
16 cited that said that trans people are more
17 likely to have chromosomal aberrations. Still
18 not likely to, but more likely than cisgender
19 people.

20 Q. Does the gene mutation mean that
21 you will -- well, is the gene mutation
22 determinative of gender -- of having a gender
23 identity that is incongruent with your
24 biological sex?

25 MS. INGELHART: Objection.

1 THE WITNESS: Do you mean is it
2 like Punnett square kind of genetics where you
3 have the big D and so you have that
4 characteristic? No. It's much more complex
5 than that.

6 Q. It's just -- the study just said
7 there's a higher tendency among transgendered
8 folk to have this particular mutation, right?

9 A. That among cisgender people. So
10 that's a gene that we think that might have
11 some influence on development of gender
12 identity, yes.

13 Q. And the twin studies, obviously, it
14 was a correlation, higher in maternal twins
15 versus fraternal twins would have this tendency
16 towards, right?

17 A. It's identical versus fraternal.

18 Q. Okay.

19 A. So identical twins share the same
20 genetics, same prenatal environment, same
21 postnatal environment, I mean, unless they're
22 separated. Fraternal twins are as genetically
23 similar as brothers and sisters, so they share
24 a lot of genetics, but not all of them, but
25 they also share the same prenatal environment,

1 the same postnatal environment, and so -- and
2 that's a very common way of determining how
3 genetically influenced a characteristic is is
4 by doing that comparison.

5 Q. Do you know the sample size of the
6 twin studies?

7 A. I think it was like over 20, less
8 than a hundred.

9 Q. And did the studies find that every
10 time one of the identical twins was
11 transgendered, the other twin would be
12 transgendered?

13 A. No.

14 Q. It would just -- there was just a
15 higher propensity?

16 A. Right. And from that, you can
17 calculate the variability.

18 Q. And then chromosomal aberrations,
19 those are the DSDs we talked about?

20 A. Well, they're in -- the one
21 particular study that I'm thinking about, they
22 just took trans people who presented for care
23 who had not previously been diagnosed with a
24 DSD, and they said let's karyotype everybody
25 with the idea of the study being to figure out,

1 gee, should we karyotype everybody who presents
2 as trans wanting gender confirmation
3 treatments. And they found that the percentage
4 was higher. I think amongst trans women, it
5 was, like, three percent than the cisgender
6 population, though -- so I guess at that point,
7 you would say, gee, those people do have a form
8 of DSD, but it was amongst people who had a
9 gender dysphoria or at the time gender identity
10 disorder diagnosis who then were discovered to
11 have the DSD because they presented as trans.

12 Q. And, again, not everyone with that
13 chromosomal aberration is going to present as
14 transgendered?

15 A. Correct.

16 Q. I mean, you said three percent, so
17 a very small portion of those people?

18 A. It -- it's a small portion of trans
19 people that have those aberrations, but then
20 it's a different question to say of people who
21 have this aberration, what percentage are
22 trans, and the study didn't assess that.

23 Q. And you don't know that answer?

24 A. No.

25 Q. But it's not all?

1 A. It's certainly not all.

2 Q. You recognize that gender identity
3 is shaped by a person's early environment,
4 right?

5 MS. INGELHART: Objection. Vague.

6 THE WITNESS: It's shaped by their
7 prenatal environment and probably to an extent
8 by their early postnatal environment.

9 Q. All right. So if you look at
10 Paragraph 25, you say: In cases -- second
11 sentence: In cases where they are incongruent,
12 of these many biological characteristics, the
13 single most important characteristic for
14 identifying sex in an individual human being is
15 their gender identity, which is determined by
16 both genetics and early environment, including
17 prenatal hormonal milieu?

18 A. Correct.

19 Q. "Milieu" or "milieu"?

20 A. "Milieu."

21 Q. I hate that word.

22 All right. So let me ask you
23 again: You admit that gender identity is
24 shaped by a person's early environment, right?

25 A. Very early environment, yes.

1 Q. Okay. And when you define gender
2 identity in Paragraph 14 of your report, you
3 don't describe it in biological terms at all,
4 do you?

5 MS. INGELHART: Objection.
6 Misstates and mischaracterizes prior testimony
7 and declarative testimony.

8 THE WITNESS: In the medicalized
9 sense of this, gender identity is a symptom you
10 use to diagnose gender dysphoria, one of -- you
11 know, they also have to have the dysphoria too.
12 And so it's something you assess, but it is
13 something that's biologically based because our
14 brains are biological entities.

15 Q. Which of the other sex
16 characteristics you identified in Paragraph 21
17 are shaped by early environment?

18 A. The hormonal milieu, gender
19 identity, and all the things that I said were
20 influenced by the hormonal milieu.

21 Q. Okay. None of these other sex
22 characteristics besides gender identity are
23 dependent upon the internal sense of one's
24 self, right?

25 A. Can you say that again?

1 Q. Yeah. None of the other sex
2 characteristics that you identify in
3 Paragraph 21 besides gender identity are
4 dependent upon the internal sense of one's
5 self, right?

6 MS. INGELHART: Objection.

7 THE WITNESS: Those influence the
8 internal sense of one's self, but you can have
9 an SRY gene or not have one and have a gender
10 identity that is male, female or somewhere
11 along the spectrum, but most of the time, if
12 you have an SRY gene, you're going to have a
13 male gender identity. So you could say
14 something influences it, but doesn't, in all
15 cases, determine it.

16 Q. So they're not dependent upon the
17 internal sense of one's self?

18 MS. INGELHART: Objection. Vague.

19 THE WITNESS: The internal sense of
20 one's self can be dependent on them.

21 MR. BLAKE: Okay.

22 MS. INGELHART: Excuse me. May we
23 take another break?

24 MR. BLAKE: Sure.

25 (Recess taken.)

1 Q. Do you agree that sex is assigned
2 at birth and refers to one's biological status
3 as either male or female and is associated
4 primarily with physical attributes, such as
5 chromosomes, hormone prevalence and external
6 and external anatomy?

7 MS. INGELHART: Objection.
8 Compound.

9 THE WITNESS: I think sex as
10 assigned at birth is influenced by genital
11 anatomy, and you usually don't have the other
12 information available to you.

13 Q. So you disagree with that
14 statement?

15 MS. INGELHART: Objection.
16 Mischaracterizes.

17 THE WITNESS: Yes.

18 Q. Do you agree that gender refers to
19 the socially constructed roles, behaviors,
20 activities and attributes that a given society
21 considers appropriate for boys and men or girls
22 and women?

23 A. I think that's gender expression.

24 Q. So you disagree with that statement
25 too?

1 A. It's not completely accurate, but I
2 could see how somebody would make that
3 statement.

4 Q. If you go to Paragraph 37 of your
5 report, Defendants' Exhibit 19.

6 A. Okay. I'm there.

7 Q. Gender identity is immutable
8 characteristic in adolescence and adults and
9 not merely feeling like the opposite sex, as
10 Dr. Van Meter suggests.

11 Do you see that?

12 A. I do.

13 Q. What forms the basis of your
14 opinion that gender identity is immutable?

15 A. There are research studies that
16 show that in late adolescence and adults,
17 gender identity is fairly accurately assessed
18 in the sense of providing people transgender
19 care, and that's why there are very few people
20 who detransition.

21 Q. What research studies?

22 A. European studies, mostly.

23 Q. Do you have --

24 A. I mean -- well, I will tell you
25 there's one study, it's older, but it looks at

1 regret, which is a way to reflect. Visions may
2 change with their expressed gender identity.
3 It's called Pfafflin & Junge. There was
4 basically a systematic review of a bunch of
5 other studies, and they found a very low regret
6 rate. I don't know if there's a systemic
7 review after that, but there's individual
8 studies that show very low regret rates.

9 Q. You can't name any of the other
10 studies, though?

11 A. I mean, I can name the centers
12 where they were done.

13 Q. Okay. Go ahead.

14 A. The Netherlands and Sweden have
15 basically one center that does their gender
16 treatment for the whole country. It's, like, a
17 tertiary referral center, and they publish
18 every so often in the literature and they both
19 report very low regret rates.

20 Q. So you are using what you have
21 called low regret rates as a synonym for
22 immutable characteristic?

23 A. People who regret having
24 transitioned are often not incorrect about
25 their gender identity, but there are an

1 occasional few people who subsequently state
2 no, my gender identity is different, and those
3 two groups of people, those who don't state
4 their gender identity is different, but they
5 regret having transitioned, and those who state
6 no, my gender identity is different together
7 comprise a very small percentage, and that
8 tells me that this is pretty accurate.

9 Q. But not immutable for those people,
10 right?

11 MS. INGELHART: Objection.
12 Misstates.

13 THE WITNESS: The ones who
14 transition back because, like my experience
15 with the few patients that I've treated, the
16 gender identity isn't changed, it's the same,
17 they just realize that it's really hard being a
18 trans person. The ones who say no, my gender
19 identity is not what I said two years ago, I
20 haven't personally treated them and I haven't
21 read any psychological description of them, but
22 I don't -- in those cases, I don't know. I
23 think there are a lot of things that would
24 motivate people to state their gender identity
25 is one way or the other, which is why people

1 may not transition until a certain point in
2 adulthood.

3 Q. And I think you said earlier, you
4 had not read any studies conducted on these
5 people who detransitioned, right?

6 A. Not that I can recall.

7 Q. And other than the Pfafflin & Junge
8 study, you can't recall any specific other
9 studies related to the immutability of gender
10 identity, right?

11 A. The studies I quoted were about
12 regret, and in that group, you could say the --
13 the -- that group comprises the upper limit of
14 what that could be.

15 Q. So it's based on the low incidence
16 of regret that you understand from your review
17 of the literature that you've concluded that
18 gender identity is immutable?

19 A. And my clinical experience of
20 people who regretted that they -- you know,
21 they'll say I -- I feel the same. I feel the
22 same way, I just can't be a trans person. It's
23 too hard.

24 Q. Are you aware of any studies that
25 have linked low incidence of regret to

1 immutability of gender identity?

2 A. There are studies that -- I don't
3 want to say this wrong -- that have looked at
4 regret rates, and I think that the biggest
5 thing was surgical outcome, like how well the
6 surgery went, but I think there were a couple
7 of other psychological characteristics that may
8 have predicted that. I can't tell you exactly
9 what they were, but that's not -- that's
10 assessment of the patient has gender dysphoria,
11 which determining what their gender identity is
12 is part of that.

13 Q. Which is different than whether or
14 not gender identity is immutable. Whether or
15 not they have gender dysphoria is a different
16 question, right?

17 A. Because it's something that is an
18 internal feeling, there's no way you can say
19 absolutely for certain. I could ask you what
20 your gender identity is and you could say it's
21 male, but I'm not a hundred percent certain of
22 that, and there are a lot of people who've said
23 yes, I'm male. I'm going to do all these
24 incredibly masculine things when, deep down,
25 that wasn't what their gender identity was. So

1 it's -- I think the question of immutability
2 is -- is not something that you can really
3 assess perfectly, but you can look at things
4 that reflect it.

5 Q. If you go to Paragraph 30 of your
6 report, let me know when you're there.

7 A. Okay.

8 Q. In that paragraph, you reference a
9 study that found that having an identity
10 document that matched their gender identity
11 reduced the risk of suicide, right?

12 A. Correct.

13 Q. Do you know how that study was
14 conducted?

15 MS. INGELHART: Vague. Objection.

16 THE WITNESS: I know it was a
17 Canadian population. I know it was
18 retrospective, and I think it was a survey.

19 Q. Do you know if it was -- do you
20 know if the participants in the study
21 volunteered for the study?

22 A. All study participants have to
23 volunteer. I mean, if you're doing medically
24 ethical research, you can't have
25 non-volunteered people in your study.

1 Q. Well, that's not true in every
2 country. I mean, countries like Sweden where
3 they have access to everybody's medical
4 information, they can just sample the medical
5 information and figure out certain risks and
6 illnesses that come out of that -- out of that
7 population if they want, but...

8 A. But the type of study where you ask
9 people to fill out a form and answer questions
10 about themselves, that, you have to get --

11 Q. So this was, as far as you know,
12 the population of the study was volunteer,
13 right?

14 A. Because it would have to be, yes.

15 Q. And do you know whether or not the
16 study involved a control group?

17 A. I think the -- essentially, the
18 control group is those who did not have an
19 identity document, so you're comparing what is
20 the benefit of having an identity document
21 versus the group that doesn't have identity
22 documents.

23 Q. Do you know whether the study
24 controlled for the type of identity document?

25 A. I know they listed -- when they

1 described it, they said an identity document,
2 for example, and they listed several possible
3 identity document.

4 Q. But you don't know whether the
5 study itself looked at outcomes based on the
6 type of identity document that was incongruent,
7 right?

8 A. Oh, you mean, like student ID
9 versus driver's license?

10 Q. Sure.

11 A. I don't believe they were that, no.

12 Q. And do you know whether the study
13 was conducted just on people from Ontario or
14 Canada or do you know if the study included
15 people from other countries?

16 A. I know it was just Canada. I can't
17 remember the province, so...

18 Q. Are you aware of any similar study
19 that's been conducted in the United States?

20 A. No.

21 Q. Do you know whether transgendered
22 individuals who were born in Ohio have a higher
23 or lower rate of suicide than transgendered
24 individuals born in other states?

25 A. No.

1 Q. Could be higher?

2 A. Certainly.

3 Q. Could be lower?

4 A. Certainly.

5 Q. You just don't know?

6 A. Yeah. I haven't read that or read
7 a study about that, although the National
8 Transgender Discrimination Survey might have
9 had something about that. I don't know. I
10 know they assessed --

11 Q. Sorry. That's the what again?

12 A. The National Transgender
13 Discrimination Survey.

14 Q. Who publishes that?

15 A. Well, it was -- it's a data set
16 that was created by the National Center of
17 Transgender Equality, and I couldn't tell you
18 exactly who else, but it was a national survey
19 of trans people. And they published, but also
20 they make their data set available to other
21 researchers, so there are other studies that
22 are published that are sub-studies from that.

23 Q. Do you have access to that
24 information?

25 A. No. I could, but...

1 Q. Have you looked at that
2 information?

3 A. I've looked at the -- their -- the
4 main presentation of the data and I've read at
5 least one article that was done by researchers
6 on the data set that was subsequent, and I
7 think there was also one that was based on
8 transgender people of color, specific to that,
9 to subsets of it.

10 Q. And you think it's possible that
11 that survey contains information related to
12 suicide rates of transgendered people from
13 Ohio?

14 A. It definitely looks at suicide
15 rates, and I -- they assessed the state that
16 people were in, and so -- and I don't know if
17 they assessed state of birth, I'm not sure, but
18 it's certainly possible.

19 Q. Okay. Do you know whether the
20 Ontario study controlled for people who had a
21 diagnosis of gender dysphoria?

22 A. I don't recall from the paper.

23 Q. Do you know whether the study
24 controlled for people in varying stages of
25 transition?

1 A. Again, I don't recall 'cause I
2 haven't read it super recently.

3 Q. Do you believe that a diagnosis of
4 gender dysphoria should be required before a
5 person is able to change the sex marker on his
6 or her birth certificate?

7 MS. INGELHART: Objection. Calls
8 for a legal conclusion. You can answer.

9 THE WITNESS: I don't think that's
10 the best way to do it because I think that
11 delays patient access to a very important
12 treatment.

13 Q. Do you know whether the plaintiffs
14 in this case have received a diagnosis of
15 gender dysphoria?

16 A. I don't know if it's in the
17 complaint, but I wouldn't know if it's not in
18 the complaint.

19 Q. Do you agree that the diagnosis of
20 gender dysphoria is the distress a person feels
21 due to a conflict between their gender identity
22 and their sex assigned at birth?

23 A. Yes, as much as sex assigned at
24 birth reflects how society treats you and the
25 expectations it has for you.

1 Q. And a person's gender identity does
2 not determine their sex at birth, right?

3 MS. INGELHART: Objection. Vague.
4 You can answer.

5 THE WITNESS: I think a person's
6 gender identity is the best way to determine
7 the marker that should be on their birth
8 certificate, but I think that you can't assess
9 that a birth. So that's not how you -- you
10 can't do that prospectively, but you can do it
11 retrospectively.

12 Q. Do you believe that a person should
13 undergo a certain amount of transition before
14 requesting a change to the sex marker on their
15 birth certificate?

16 A. I think social transition is one of
17 the first things people do, and getting gender
18 marker changes is an important part of that, so
19 that's kind of one of the first steps.

20 Q. You think that having your sex
21 marker on your birth certificate changed is a
22 part of the social transition?

23 A. All of the gender markers on your
24 identity documents.

25 Q. You agree that no amount of gender

1 transition can change a person's chromosomes,
2 right?

3 A. Correct.

4 Q. And no amount of gender transition
5 can change the sex of the individual as
6 identified by the medical provider at the time
7 of birth, right?

8 MS. INGELHART: Objection. Vague.
9 You can answer.

10 THE WITNESS: I think in the case
11 of people who are transitioning and the medical
12 provider at birth made a mistake, a very
13 understandable mistake because you're playing
14 the odds at that point, and so I think the sex
15 assigned at birth is the incorrect data point.

16 Q. And that's not changed, obviously,
17 right?

18 MS. INGELHART: Objection.

19 THE WITNESS: What they did in the
20 past?

21 Q. Correct.

22 A. You can't change the past. I mean,
23 that's -- time flows in one direction.

24 Q. Do you know how many times each of
25 the plaintiffs in this case have been required

1 to disclose their birth certificates?

2 A. I know from reading the complaint
3 that, as I recall, there's a couple of
4 instances where they said that there were. I
5 don't know how many total they have, but I know
6 it's at least the number that were in the
7 complaint.

8 Q. Are you familiar with the
9 circumstances for each of the disclosures?

10 A. Just as much that's in the
11 complaint.

12 Q. Do you know whether any of the
13 plaintiffs feared physical harm when they
14 disclosed their birth certificate?

15 A. When they initially disclosed it or
16 when they got the negative consequences of
17 disclosing it?

18 Q. When they disclosed their birth
19 certificate in the circumstances described in
20 the complaint.

21 A. I think they describe being
22 fearful. Like, for example, the woman who's a
23 truck driver who had to leave her job because
24 of that.

25 Q. Do you know whether she feared

1 physical harm?

2 MS. INGELHART: Objection.

3 Foundation. Asked and answered.

4 MR. BLAKE: I'm asking for the
5 foundation, does he know.

6 THE WITNESS: Well, she said that
7 somebody threatened to, quote, beat her ass, so
8 I would be afraid of that. I think most people
9 would. And I think trans people have a good
10 sense of how dangerous these situations can be.

11 Q. So other than the circumstances
12 described in the complaint, are you aware of
13 any other instances where any of the plaintiffs
14 feared physical harm as a result of disclosing
15 their birth certificate?

16 A. No.

17 MS. INGELHART: Objection.
18 Speculation.

19 Q. Do you believe that the medical
20 provider erred when they identified and
21 recorded the sex at the time of birth on each
22 of the plaintiffs' birth certificates?

23 A. An understandable error, but yes.

24 Q. Do you believe that medical
25 providers should be required to conduct any

1 additional medical procedures to determine a
2 child's sex at birth?

3 MS. INGELHART: Objection. Calls
4 for a legal conclusion. You can answer.

5 THE WITNESS: If there's ambiguity,
6 that's generally done. There's no way you can
7 assess for what somebody's adult gender
8 identity is going to be outside of the cases of
9 children with DSDs, and so I don't think that's
10 possible then.

11 Q. What is, in your opinion, the rate
12 of chromosomal abnormalities in the XX or XY
13 karyotype in the general population?

14 MS. INGELHART: Objection.
15 Speculation. You can answer.

16 THE WITNESS: I think I said it
17 somewhere in my report, but I think it's, like,
18 one in 500, one in a thousand, somewhere there.

19 Q. Okay. And then for transgender
20 people, do you think there's a different rate?

21 A. There was the one study that --
22 there is only one study that I know that looked
23 at karyotypes and there was a higher rate. It
24 was three percent amongst trans women and less
25 than that, but I can't remember what it was for

1 trans men.

2 Q. Okay. So you'd agree, then, that
3 it's rare for someone to have one of those
4 abnormalities, right?

5 A. Correct.

6 Q. Transgendered or cisgendered?

7 A. Correct.

8 Q. And there's no evidence suggesting
9 that any of the plaintiffs have one of those
10 abnormalities, right?

11 MS. INGELHART: Objection.
12 Speculation. You can answer.

13 THE WITNESS: By virtue of the fact
14 that they're trans, their chance is higher, but
15 if you're playing the odds, if you're going to
16 bet on this, I would bet no.

17 Q. Yeah. I mean, at the most, it's
18 three in a hundred, right?

19 A. Yeah. So there's a one in 30
20 chance that --

21 Q. So you can't be certain. There is
22 a 97 percent chance that each of the plaintiffs
23 have a normal karyotype that matches their
24 other biological sex characteristics, right?

25 MS. INGELHART: Objection. Vague.

1 THE WITNESS: Ninety-seven percent
2 is reasonable, yeah.

3 - - - - -

4 (Thereupon, Deposition Exhibit 23,
5 Rebuttal Expert Report, was marked
6 for purposes of identification.)

7 - - - - -

8 Q. You've just been handed an exhibit
9 marked as Exhibit 23, which is the rebuttal
10 expert report of Dr. Quentin Van Meter
11 regarding the expert report of Dr. Randi C.
12 Ettner, Ph.D. do you see that?

13 A. I do.

14 Q. Is this one of the documents that
15 was provided to you prior to today's
16 deposition?

17 A. Prior to today, yes, but not prior
18 to my report.

19 Q. Yeah. This actually came out at
20 the same time that your report was written, so
21 it would have been impossible for you to review
22 prior to that.

23 If you turn to the second page,
24 look at Paragraph 10. It says: In truth,
25 there are no valid published studies that find

1 a biological basis for gender identity, and
2 Dr. Ettner does not cite to any such studies in
3 her expert report.

4 Do you see that?

5 A. I do.

6 Q. Do you agree with that conclusion?

7 A. The second sentence about
8 Dr. Ettner not citing, I would have to go
9 through her report and look for it.

10 Q. It either does or it doesn't?

11 A. Correct.

12 Q. What about the first sentence?

13 A. The first sentence, I don't think
14 that's correct.

15 Q. Okay. What -- what valid published
16 studies find a biological basis for gender
17 identity?

18 A. As an example, Milton Diamond's
19 twin study that I cited.

20 Q. Okay. So this is the twin study,
21 the functional MRI study?

22 A. No.

23 Q. No. All right. When ones are
24 they?

25 A. It's the twin study that compared

1 identical versus fraternal twins for
2 concordance as far as transgender status.

3 Q. Is that the only one that you're
4 aware of?

5 A. There was some other studies that I
6 cited that showed a gene that was more common
7 amongst transgender people.

8 Q. Which studies?

9 A. If you go to Page 13 of my report,
10 Citation No. 6 are a few examples.

11 Q. The sex steroid related genes in
12 male to female transsexualism?

13 A. Yeah. There's a few, but they're
14 in there.

15 Q. Oh, it's all the ones in
16 Footnote 6?

17 A. And five.

18 Q. And five. Okay. Any other ones?

19 A. There may be more out there. I
20 could do a literature search, but these are the
21 ones that come to mind.

22 Q. These are the ones that you're
23 aware of?

24 A. Correct.

25 Q. And you relied on those in forming

1 the opinions in your report?

2 A. I did.

3 Q. Okay. Paragraph 11 of
4 Dr. Van Meter's rebuttal report,
5 Defendants' 23: Dr. Ettner states elsewhere in
6 Paragraph 20 that the gender identity is
7 determined merely by the statement of the
8 adolescent or adult. Mere statements by the
9 individual, obviously, do not indicate a
10 biological basis for gender identity, nor do
11 such statements indicate that gender identity
12 is immutable.

13 Do you agree with the conclusion
14 that Dr. Van Meter makes in Paragraph 11?

15 A. Could I look at Dr. Ettner's
16 report, her Paragraph 20?

17 Q. You sure can.

18 MR. BLAKE: Just take a quick
19 break. I'll run and get it.

20 (Recess taken.)

21 Q. I've just handed you what's been
22 previously marked as Defendants' 11,
23 Exhibit 11, which is a copy of the report
24 authored by Dr. Randi Ettner in this matter.
25 If you turn to Page 5 of the report,

1 Paragraph 20, you can read it there.

2 A. Okay.

3 Q. So if you turn back to
4 Paragraph 11, Dr. Van Meter's rebuttal, do you
5 disagree with the first -- or do you agree with
6 the first sentence in Paragraph 11?

7 A. There are a lot of things in
8 medicine that depend on subjective and
9 objective data. So, for example, if somebody
10 comes in with a kidney stone to the ER and they
11 say their -- we ask them to rate their pain,
12 how bad is your pain, it's a nine out of ten.
13 But then I also look at them, they're sweating,
14 they're writhing around on the table, and those
15 things correspond. There's no conflict between
16 the two. If that same person says nine out of
17 ten and they're sitting there posting on
18 Twitter or playing a video game, it makes you
19 think, gee, why don't these things coincide.

20 In the case of what Dr. Ettner said
21 is you assess the person's gender identity by
22 self-disclosure, it's not just I'm a boy, I'm a
23 girl, it's disclosure of, oftentimes, a lot
24 more nuanced bit of data, but it is subjective,
25 however, you use that subjective data with

1 objective data. You know, if a person is
2 obviously responding to internal stimuli and
3 you think they might be psychiatric, maybe you
4 say, well, gee, let's address that first and
5 then see if this changes, right. And that's a
6 rare instance where somebody may state they
7 have a gender identity that's different. So
8 disclosure is a lot more complicated than I'm a
9 boy, I'm a girl, however, it is a subjective
10 experience, just like pain is.

11 Q. So do you agree with Dr. Ettner
12 when she says it is detectable by
13 self-disclosure and in adolescents and adults?

14 A. Yes.

15 Q. So do you agree with, then, what
16 Dr. Van Meter says in Paragraph 11 where he
17 says mere statements by the individual,
18 obviously, do not indicate a biological basis
19 for gender identity? Do you agree with that
20 statement?

21 A. No, I don't.

22 Q. Okay. Nor do such statements
23 indicate that gender identity is immutable. Do
24 you agree with that statement?

25 A. I don't think that follows from

1 saying gender identity is subjective. You can
2 have subjective things that change or don't
3 change. In this case, I don't think gender
4 identity in adults or -- and later, adolescents
5 appreciably changes, so I don't think it's the
6 case that -- but I don't think that follows
7 from the same data.

8 Q. How does a statement by an
9 individual -- or how does a self-disclosure of
10 gender identity in an adolescent or adult
11 indicate a biological basis for gender
12 identity?

13 A. Every feeling, emotion and thought
14 we have is because of our brain, and so -- I
15 mean, it's like the American Psychiatric
16 Association's constant drumbeat, depression is
17 a disorder of chemistry, not character, right.
18 So if someone says my gender identity is
19 whatever, that's a function of the brain, it's
20 not -- you know, we don't assess supernatural
21 or things like that in medicine. You know,
22 gender identity is a function of your brain, so
23 obviously, that's biological. All of
24 psychiatry is biological.

25 Q. And you think a person's statement

1 about their gender identity necessarily
2 indicates that there is a biological basis for
3 their gender identity?

4 MS. INGELHART: Objection.
5 Misstates and mischaracterizes, but you can
6 answer.

7 THE WITNESS: You can't have a
8 gender identity except as a function of your
9 brain. It's -- it is a -- I mean, our brains
10 produce the feelings that we experience, the
11 thoughts that we have, the words that we say.
12 Our identity -- our gender identity, our
13 identity is -- you know, my identity as a
14 physician, your identity as an attorney, those
15 are all functions of our brain, and so by
16 definition, that's biology.

17 Q. To use your example, the person
18 who's indicating a pain of nine while they're
19 on their phone tweeting or texting or doing
20 whatever, they're not being honest with what
21 their biological response is happening at that
22 moment, right?

23 A. I like to think of them as not
24 being dishonest, but having an incomplete
25 understanding of the question I'm asking. And

1 so, I mean, yeah, sometimes people lie to you,
2 but you can figure that out. And so it's
3 not -- it's not -- like assessing pain, it's
4 not just saying, gee, what is your pain on a
5 zero-to-ten scale, there's a lot more into
6 doing that. And when Randi's talking about
7 self-disclosure, it's not just check the box
8 male or female, it's, well, tell me about this.
9 When did you first feel this? You know, did it
10 change at all during adolescence? How do you
11 experience it now? Do you experience it the
12 same way in different context? I mean, it's a
13 lot more than just saying -- or, you know,
14 check one box male or female.

15 Q. And you think that that more
16 detailed psychological evaluation indicates a
17 biological basis for gender identity, then?

18 MS. INGELHART: Objection.
19 Mischaracterizes. Go ahead.

20 THE WITNESS: I think, and this is
21 something maintained by both APAs, that our
22 identities, our mental health problems, if we
23 have them, they're biologically based, you
24 know. It's -- depression is a disorder of
25 chemistry. When we drink an alcoholic

1 beverage, it's not that our soul gets drunk,
2 it's that our brain gets drunk.

3 Q. If you read Paragraph 12 of
4 Dr. Van Meter's expert report, he says: In
5 addition, both the APA handbook and the DSM-5
6 state that there is no biological basis for
7 gender identity.

8 Do you disagree with that
9 statement?

10 A. I -- actually, when I read this, I
11 reread the DSM-5 section about that, and I
12 don't find that there, so I do disagree with
13 that.

14 Q. Okay. If you go to Paragraph 14 on
15 the next page. And starting with the second
16 sentence: Dr. Kenneth Zucker and others have
17 published studies from clinical experience that
18 show between 80 and 98 percent of gender
19 incongruent patients return to identification
20 with their biologic sex if evaluated and
21 counseled consistently through natural puberty
22 to adulthood, and none of these patients were
23 subject to aversion, treatments or electroshock
24 therapy.

25 Are you familiar with Dr. Zucker's

1 study?

2 A. Yes, and Dr. Zucker.

3 Q. Do you agree with his conclusions
4 of his study?

5 A. I don't agree with the way that
6 Dr. Van Meter states that, and I don't think
7 Ken would be either. Ken's a pediatric
8 psychologist, and so when he talks about
9 desistance, it's among kids. If -- I mean, I
10 know Ken and I've talked to him. If you ask
11 him does he think an 18-year-old person who is
12 transgender, is there a way to change that
13 person, no. It is the case, and Ken has noted,
14 just as, you know, every other pediatrician
15 that I know who treats trans kids has noticed
16 that it's not fixed until the early part of
17 puberty. And so there are -- you know, people
18 come up with different percentages that they
19 think persist and desist, but this is
20 prepubertal children, and Ken doesn't think
21 that adults can change. I mean, he doesn't
22 support reparative therapy for adults.

23 Q. Do you agree with Dr. Van Meter
24 that this demonstrates that gender identity is
25 not immutable, and, in fact, is fluid during an

1 individual's life?

2 A. It's like we talked about before,
3 there are things that tend to push children in
4 one direction or the other, and those things
5 can be present from the moment of conception,
6 but childhood is a huge developmental time, and
7 so children may be very fluid about their
8 gender in childhood. I mean, Ken's method of
9 treating children before he was taken out of
10 his position at CAMH -- that's C-A-M-H, it's an
11 abbreviation -- was that you don't treat
12 children adversely for doing gender
13 nonconforming behavior, but you praise them for
14 gender conforming behavior, which, I mean, kids
15 aren't that dumb. They're going to kind of
16 know that the parents have a preference. If
17 you -- so he's different than a lot of other
18 people, like Norm Spack at Boston Children's or
19 Joe Olsen at Children's Hospital LA. Their way
20 of dealing with this is, look, let the kid be
21 who they feel like they are. Don't impose any
22 of your ideas on them. Let the kid figure out
23 who they are because that's a lot of what
24 childhood is and adolescence is is figuring out
25 who you are. And protect your kid and praise

1 your kid no matter what they do as long as what
2 they're doing is not bad or dangerous. And so
3 he's a little different in how he treated kids,
4 but nobody disagrees that adolescence isn't the
5 sort of point where that's determinable, later
6 adolescence.

7 Q. If you go to paragraph 15, it says:
8 Moreover, actual published studies show a
9 19-fold increase in completed suicides in those
10 who completed the entire gender affirmation
11 process (social affirmation, medical treatment
12 and surgical manipulation).

13 Do you agree with that sentence?

14 A. Given the 19-fold, I'm pretty sure
15 he's referring to Cecilia Dhejne's study from
16 2011 or 2012 that is often misquoted, and she
17 gets very upset when that happens because the
18 study was just do trans people, after
19 treatment, need more mental health care, you
20 know, have more indication for it. It wasn't
21 an assessment of whether or not the treatment
22 worked. In fact, her -- in her discussion
23 section, she said, look, if you look at people
24 who have bipolar disorder or schizophrenia who
25 are treated the way we treat people with

1 bipolar disorder and schizophrenia and you look
2 at them afterwards, they have a greater risk of
3 these same types of morbidity, suicidal
4 ideations, psychiatric hospitalizations, but it
5 doesn't follow that the antipsychotics or the
6 mood stabilizing agents were the cause. In
7 fact, it might have been worse if you hadn't
8 treated them. So she specifically says in the
9 study you cannot look at this as an assessment
10 of whether or not these treatments work.

11 And, in fact, the same group, the
12 same patient group, they -- it wasn't --
13 Cecilia wasn't in this one, but it was the same
14 center published like this month in the
15 American Journal of Psychiatry and actually
16 looked at the question of does it help, and
17 they found that getting surgery definitely
18 didn't help. In fact, on average, your need
19 for mental health treatment decreased eight
20 percent per year after you had your last
21 surgery.

22 Q. Do you know whether the study has
23 been conducted comparing those who have gone
24 through transition or gender affirmation
25 process with those who -- I think the term you

1 used was desistance; is that right?

2 A. Desistance.

3 Q. Desistance. So let's start over.

4 Do you know whether this study that
5 showed the 19-fold increase, whether that group
6 has been compared to those who have desisted?

7 A. That study -- the study that he's
8 referring to and the study I just mentioned are
9 all in adult patients, so adolescent desistance
10 isn't pertinent. I mean, nobody's going to
11 desist after the onset of the study.

12 They did, in the other study, the
13 one that was just recently published, looked at
14 people who had not yet gotten treatment
15 compared with people who had gotten treatment
16 and they compared their mental health outcomes.

17 Q. Are you aware of a study looking at
18 people who have desisted and looking at their
19 suicide rates?

20 A. Oh, at their suicide rates? No. I
21 think Peggy Cohen-Kettenis,
22 C-o-h-e-n-K-e-t-t-e-n-i-s, that might be the
23 correct spelling, something like that, her
24 group, I think, did a follow-up study on
25 children who desisted, though I'm not sure if

1 they assess suicide ideation.

2 Q. So do you agree or disagree with
3 the statement that these studies indicate that
4 gender incongruent patients who undergo
5 appropriate treatment and return to
6 identification with their biologic sex are at
7 far less risk for suicide?

8 A. I don't think there are any studies
9 that looked at that. And, no, that's not what
10 the Dhejne study showed. And it's D-h-e-j-n-e.

11 Q. It's not how I wrote it in my
12 notes. I was thinking of the former running
13 back from Wisconsin, Ron Dayne.

14 A. The only people who were studied,
15 though, were people who were still treated at
16 the clinic.

17 MR. BLAKE: I think I'm done.

18 MS. INGELHART: Can we go off the
19 record for a moment?

20 (Recess taken.)

21 EXAMINATION OF RYAN GORTON, M.D.

22 BY MS. INGELHART:

23 Q. I'm going to ask you a few
24 questions, Dr. Gorton. If you can remember
25 that the court reporter's still sitting to your

1 left, despite the fact that I'm on your right.

2 We just discussed -- or you just
3 discussed the Dhejne study previously with
4 Mr. Blake, right?

5 A. We did.

6 MR. BLAKE: Objection.

7 Q. Did you refer do another newer
8 study as it relates to that one?

9 A. Yes.

10 Q. What study was that?

11 A. It was in this months American
12 Journal of Psychiatry, and it was the same
13 patient population group.

14 Q. Okay. I'd like to add that.

15 MS. INGELHART: I don't know what
16 number exhibit plaintiffs we're on, but can we
17 introduce this a plaintiffs' next exhibit?

18 - - - - -

19 (Thereupon, Deposition Exhibit A,
20 Study, was marked for purposes of
21 identification.)

22 - - - - -

23 Q. I've just placed in -- or had
24 placed before you Plaintiffs' Exhibit A. Is
25 that the study you were referring to?

1 A. It is.

2 Q. Okay. Thank you.

3 In developing your report and your
4 testimony and providing your testimony today,
5 do you rely on your practical experience
6 treating transgender patients?

7 A. I do.

8 Q. Is there a distinction between
9 gender identity disorder and gender dysphoria?

10 A. Gender identity disorder was the
11 nomenclature in DSM-IV, gender dysphoria is
12 nomenclature in DSM-5, and there are a couple
13 of differences in the diagnostic criteria.

14 Q. What are those differences?

15 A. For GID -- sorry. For gender
16 dysphoria in adults and adolescents, from
17 DSM-IV to DSM-5, they got rid of DSDs as a
18 rule-out. That is it used to be the case that
19 if you had a DSD, you couldn't be diagnosed
20 with gender dysphoria, or, at the time, gender
21 identity disorder, but now it's not considered
22 a rule-out.

23 And then in the pediatric
24 diagnosis, in the previous version and in this
25 version, there are a list of diagnostic

1 characteristics. So, for example, does the kid
2 say they have a gender identity that's
3 different than the one they were assigned at
4 birth? Do they typically play according to
5 stereotypical games of that gender? Do they
6 like to play with playmates of that same gender
7 in the same way that girls typically like to
8 play with girls and boys typically like to play
9 with boys? The one big difference is that,
10 previously, that the child says their gender
11 identity is different wasn't the requirement.
12 That is, you had to have -- it was either four
13 out of five or five out of six things, and it
14 could be any of them. So you could have a kid
15 who doesn't identify as a gender different from
16 their sex as assigned at birth, but who, you
17 know, has gender atypical play and, you know,
18 wears the clothes of the other gender and all
19 these sort of behavioral characteristics. You
20 could actually diagnose that kid with gender
21 identity disorder without them identifying as
22 being transgender in any way. The current one
23 still has that same list and you still have to
24 have -- it's either four out of five or five
25 out of six, but one of them has to be the

1 child's identity.

2 Q. So does that mean that there are
3 some children who could have been diagnosed in
4 the past as having gender identity disorder,
5 but wouldn't be diagnosed today as having
6 gender dysphoria?

7 A. Yes. And I think that was actually
8 a motivation for the change.

9 Q. Do you know anybody involved in
10 that changed development?

11 A. Ken Zucker was the lead for the
12 section on gender disorders in children. And
13 he and I actually talked about it previously at
14 some conference, and he very much wanted that
15 change because he felt that, previously, you
16 could take kids who just were gender
17 nonconforming and inappropriately diagnose them
18 as having gender identity disorder, and so that
19 sort of diluted the group of children in that
20 there's one group that, you know, maybe this
21 kid is just going to be -- is just going to
22 grow up to be a gender nonconforming adult but
23 not trans identified, and then there's another
24 subgroup that are kids who their chance of
25 identifying as trans in adulthood is greater,

1 and so if you get rid of ones that are just
2 generally nonconforming, you'll have a more
3 accurate diagnostic pool.

4 Q. Is it possible that this tightening
5 of nomenclature could -- or of diagnostic
6 criteria could affect these rates of desistance
7 of children that you've seen reported?

8 MR. BLAKE: Objection. Foundation.
9 Speculation.

10 THE WITNESS: I think that is the
11 case because you have a -- you know, the
12 primary diagnostic criteria for gender
13 dysphoria is do you think, feel that your
14 gender identity is different from what you're
15 assigned at birth, and I think that was
16 actually one of Ken's motivations because he
17 did see kids referred to him that just had
18 gender non-normative behaviors and this kid is
19 maybe going to grow up to be a gender
20 nonconforming gay man, but he's not trans.

21 Q. Is there a difference between
22 desistance and detransition?

23 A. Yes. Desistance is what you talk
24 about in preadolescent children who their
25 gender identity is fluid, it changes, and as

1 adults, they don't identify in a way that we
2 would consider transgender. And
3 detransitioning is something -- phenomenon you
4 think about with adults where they've done
5 something, they've done social, medical or
6 surgical transition, and then they want to
7 reverse part of that.

8 Q. Is applying desistance to a
9 discussion of adults medically reasonable?

10 MR. BLAKE: Objection. Vague.

11 Q. Yeah. Is it -- is applying
12 desistance -- yeah. Strike that.

13 Is applying discussion of
14 desistance and that -- those data sets to adult
15 populations a reliable way of understanding
16 adult populations?

17 MR. BLAKE: Same objection.

18 THE WITNESS: You just don't talk
19 about that with adults. That's like a
20 pediatric phenomenon. So if you look at the
21 pediatric literature, they talk about
22 desistance rates, and it's all about kids, they
23 grow up and they either do have or don't have
24 that same cross-gender identity. And in
25 adults, it's -- it's really about do you

1 transition or detransition. So people don't
2 talk about those the same way.

3 Q. Okay. In your expert opinion, is
4 gender identity immutable?

5 A. In adults, yes.

6 Q. Is conversion therapy a treatment
7 accepted by the mainstream medical
8 establishment?

9 MR. BLAKE: Objection.

10 THE WITNESS: No. It's sort of
11 fringe treatment that's nobody that treats
12 trans people that I know of would ever do that.

13 Q. And why is that?

14 A. Because it's -- one, 'cause it
15 doesn't work; but, two, because it's harmful to
16 people who undergo it.

17 Q. Okay. Is genital presentation at
18 birth used as a proxy for determining the sex
19 to be marked on a birth certificate?

20 A. Yes.

21 Q. Why is it important to your clients
22 or patients, for them to have identity
23 documents that affirm their gender?

24 A. For a couple of reasons. One, if
25 people present identity documents that are not

1 congruent with their presentation, they're
2 vulnerable to interpersonal violence,
3 harassment, denial of services, and all those
4 things could make their dysphoria worse. It's
5 also the case that because of prior bad
6 experiences using incongruent identity
7 documents, people sometimes just don't do those
8 things. They stay in a bad job that they don't
9 like because it's too scary to try to apply for
10 a better job, they don't go back to school,
11 they don't register to vote, they don't request
12 services that they might be entitled to, so
13 it's -- there's a social withdrawal element.
14 And then, also, there's sort of a protective
15 effect in that if they are in a situation where
16 their gender presentation is challenged, like,
17 hey, you don't belong in this room, this is the
18 women's restroom and they could produce
19 identification that says female, that's saved a
20 few of my patients from some really bad
21 situations.

22 Q. Is it important that, in your
23 experience, for your patients to have -- your
24 transgender patients to have identity documents
25 that consistently mark their sex or gender

1 across all documents?

2 MR. BLAKE: Objection. Vague.

3 THE WITNESS: Yes. Also for a
4 couple of reasons. One, if people have -- or
5 in different situations, different identity
6 documents are requested. So if you're using a
7 credit card at a store, they might ask for your
8 driver's license or passport to verify your
9 identity. In some places, you need to have
10 your birth certificate to verify your identity.
11 So if people don't have all of their identity
12 documents correct, then it doesn't limit them
13 as much as if none of their identity documents
14 were correct, but it does limit them.

15 But then in addition, when people
16 have non-matching documents, that can expose
17 them to extra scrutiny. Like, for example, a
18 for a while, the Social Security Administration
19 was if people's gender identity in their system
20 didn't match the form that was sent in by their
21 new employer, they sent a letter to the
22 employer saying there was a mismatch outing my
23 patients as trans to their employers who may
24 not have known that.

25 It's also, if somebody's trying to

1 get security clearance or something like that,
2 having identity documents that don't match is a
3 big red flag.

4 Q. Okay. So let's refer back to
5 Defendants' Exhibit 18, Dr. Van Meter's July 1
6 report. Let me know when you have that in
7 front of you.

8 A. Okay. I have it.

9 Q. Okay. Can we turn to Page 5 and
10 look at, for example, Paragraph 31. Let me
11 know when you're there.

12 A. I'm there.

13 Q. I think there's five sentences in
14 this paragraph. Could you read the last one
15 for me?

16 A. Ray's Ohio birth certificate, if it
17 includes an entry of male, accurately reflects
18 Ray's sex.

19 Q. What did you understand that
20 sentence to mean?

21 A. That Dr. Van Meter, in the case of
22 a transgender woman whose sex I think is
23 female, agrees with Ohio's policy of keeping it
24 as male, that Dr. Van Meter doesn't think it
25 should be changed and doesn't think that my

1 understanding of sex and the understanding of
2 the medical community that treats transgender
3 patients understanding of sex is correct.

4 MS. INGELHART: Okay. Thank you.
5 I don't think we have any further questions.

6 EXAMINATION OF RYAN GORTON, M.D.

7 BY MR. BLAKE:

8 Q. Is it your testimony that the
9 DSM-IV misidentified transgender individuals?

10 A. I think the DSM-IV allowed
11 clinicians to misidentify people as transgender
12 that probably weren't and wouldn't currently be
13 diagnosed with gender dysphoria.

14 Q. Do you have any basis or idea of
15 how many people were misidentified as
16 transgender using the criteria in the DSM-IV?

17 A. Enough that Ken saw it in the kids
18 who were being referred to him at CAMH. I -- I
19 can't tell you a study of that, but there's not
20 one that I know of.

21 Q. So that's just your guess?

22 A. I know that it happened because
23 I've talked to a pediatric psychologist who
24 said, gee, this happened and happened enough
25 that we wanted to tighten up the diagnosis, and

1 it was tightened up. And it's appropriate. I
2 mean, you shouldn't diagnose a kid with gender
3 dysphoria who doesn't identify differently than
4 their sex as assigned at birth.

5 Q. But other than that statement about
6 it happened and it happened enough times, you
7 don't have any more specifics about kids who
8 were misidentified under the DSM-IV?

9 A. Statistics, no.

10 Q. And do you have any statistics or
11 studies or any information related to the
12 misidentification of transgendered individuals
13 of the DSM-IV criteria affecting the rates of
14 desistance?

15 A. Again, this is a conversation with
16 a colleague at a conference who said he
17 observed this.

18 Q. So you don't have any scientific or
19 medical basis that you could point to that says
20 gender nonconforming individuals were
21 misidentified and that has affected the rates
22 of desistance over the last few years?

23 A. Can I point to a study in the
24 literature, no, but, I mean, you talk to your
25 colleagues.

1 Q. All right.

2 MR. BLAKE: No further questions.

3 MS. INGELHART: Cool. We'd like to
4 reserve right to review and sign.

5 (Recess taken.)

6 (The deposition was concluded at
7 4:50 p.m.)

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1 Whereupon, counsel was requested to give
2 instruction regarding the witness's review of
3 the transcript pursuant to the Civil Rules.

4
5 SIGNATURE:

6 Transcript review was requested pursuant to the
7 applicable Rules of Civil Procedure.

8
9 TRANSCRIPT DELIVERY:

10 Counsel was requested to give instruction
11 regarding delivery date of transcript.

12 Mr. Blake original regular.

13 Ms. Ingelhart copy regular.

REPORTER'S CERTIFICATE

The State of Ohio,)

SS:

County of Fairfield.)

I, Kimberly A. Kaz, RPR, a Notary Public within and for the State of Ohio, duly commissioned and qualified, do hereby certify that the within named witness, RYAN GORTON, M.D., was by me first duly sworn to testify the truth, the whole truth and nothing but the truth in the cause aforesaid; that the testimony then given by the above-referenced witness was by me reduced to stenotypy in the presence of said witness; afterwards transcribed, and that the foregoing is a true and correct transcription of the testimony so given by the above-referenced witness.

I do further certify that this deposition was taken at the time and place in the foregoing caption specified and was completed without adjournment.

1 I do further certify that I am not
2 a relative, counsel or attorney for either
3 party, or otherwise interested in the event of
4 this action.

5 IN WITNESS WHEREOF, I have hereunto
6 set my hand and affixed my seal of office at
7 Cleveland, Ohio, on this 30th day of
8 October, 2019.

9
10
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13 

14 Kimberly A. Kaz, RPR, Notary Public
15 within and for the State of Ohio
16

17 My commission expires March 31, 2023.
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Veritext Legal Solutions
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October 30, 2019

To: Ms. Kara N. Ingelhart

Case Name: Ray, Stacie, et al. v. Acton, Amy, et al.

Veritext Reference Number: 3493806

Witness: Ryan Gorton , M.D. Deposition Date: 10/8/2019

Dear Sir/Madam:

Enclosed please find a deposition transcript. Please have the
witness review the transcript and note any changes or corrections on
the included errata sheet, indicating the page, line number, change,
and the reason for the change. Have the witness' signature
notarized and forward the completed page(s) back to us at the
production address shown above, or email to production-
midwest@veritext.com.

If the errata is not returned within thirty days of your receipt of
this letter, the reading and signing will be deemed waived.

Sincerely,

Production Department

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DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3493806

CASE NAME: Ray, Stacie, et al. v. Acton, Amy, et al.

DATE OF DEPOSITION: 10/8/2019

WITNESS' NAME: Ryan Gorton, M.D.

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have made no changes to the testimony as transcribed by the court reporter.

Date Ryan Gorton, M.D.

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;

They signed the foregoing Sworn Statement; and

Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal
this _____ day of _____, 20____.

Notary Public

Commission Expiration Date

DEPOSITION REVIEW
CERTIFICATION OF WITNESS

ASSIGNMENT REFERENCE NO: 3493806

CASE NAME: Ray, Stacie, et al. v. Acton, Amy, et al.

DATE OF DEPOSITION: 10/8/2019

WITNESS' NAME: Ryan Gorton, M.D.

In accordance with the Rules of Civil Procedure, I have read the entire transcript of my testimony or it has been read to me.

I have listed my changes on the attached Errata Sheet, listing page and line numbers as well as the reason(s) for the change(s).

I request that these changes be entered as part of the record of my testimony.

I have executed the Errata Sheet, as well as this Certificate, and request and authorize that both be appended to the transcript of my testimony and be incorporated therein.

11/23/19
Date

[Signature]
Ryan Gorton, M.D.

Sworn to and subscribed before me, a Notary Public in and for the State and County, the referenced witness did personally appear and acknowledge that:

They have read the transcript;

They have listed all of their corrections in the appended Errata Sheet;

They signed the foregoing Sworn Statement; and

Their execution of this Statement is of their free act and deed.

I have affixed my name and official seal this _____ day of _____, 20____.

Notary Public

see attached CA Jurat

Commission Expiration Date

CALIFORNIA JURAT WITH AFFIANT STATEMENT

GOVERNMENT CODE § 8202

- ☒ See Attached Document (Notary to cross out lines 1-6 below)
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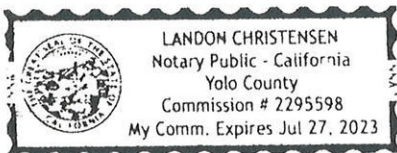
Subscribed and sworn to (or affirmed) before me

on this 23 day of November, 2019,
 by _____ Date _____ Month _____ Year _____

(1) Ryan Gorton

(and (2) _____),
 Name(s) of Signer(s)

proved to me on the basis of satisfactory evidence to
 be the person(s) who appeared before me.



Place Notary Seal and/or Stamp Above

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Completing this information can deter alteration of the document or
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 Document Date: 11/21/19 Number of Pages: 1
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ERRATA SHEET

VERITEXT LEGAL SOLUTIONS MIDWEST

ASSIGNMENT NO: 3493806

PAGE/LINE (S) / CHANGE / REASON
 P20 Line 6 / "weren't women" should be "weren't cisgender women" / missing word/clarification

P32 Line 22 / "Graham" should be "Grimm" / spelling

P44 Line 5 / "going a systemic review" should be "doing a systematic review" / wrong word

P44 Line 6 / "systemic" should be "systematic" / wrong word

P44 Line 20 / "systemic" should be "systematic" / wrong word

P45 Line 9 / "systemic" should be "systematic" / wrong word

P46 Line 25 / "systemic" should be "systematic" / wrong word

P56 Line 16 / the word "case" should appear after Alabama / missing noun/clarification

P63 Line 25 / "moved onto the Y chromosome." should read "moved onto the X chromosome." / wrong word

P70 Line 5 / "heed" should be "read" / wrong word

P92 Line 11 / "preadolescence" should be "preadolescent" / wrong word

P95 Line 4 / "renal" should be "adrenal" / wrong word

P99 Line 18 / "the between study" should be "the twin study" / wrong word

P102 Line 14 / "present" should be "presence" / wrong word

SEE ATTACHED FOR ADDITIONAL CORRECTIONS

11/23/19

Date



Ryan Gorton, M.D.

SUBSCRIBED AND SWORN TO BEFORE ME THIS _____

DAY OF _____, 20____.

Notary Public

see attached GA Jurat

Commission Expiration Date

ERRATA SHEET ADDITIONAL PAGE

ASSIGNMENT NO. 3493806 (GORTON DEPOSITION)

PAGE/ LINE /	CHANGE	/REASON
P103 Line 6 /	“vaginal plasty” should be “vaginoplasty”	/ spelling
P123 Lines 2-3 /	“a typical” should be “atypical”	/ spelling
P124 Line 7 /	“incidents” should be “incidence”	/ spelling
P141 Line 21 /	“than” should be “that”	/ wrong word
P157 Line 12 /	“as” should be “at”	/ wrong word
P162 Line 5 /	“three percent” should be “three percent higher”	/ missing word/clarification
P174 Line 3 /	“document” should be “documents”	/ plural
P175 Line 5 /	“National Center of Transgender Equality” should be “National Center for Transgender Equality”	/ wrong word
P178 Line 9 /	“a birth” should be “at birth”	/ wrong word
P189 Line 3 /	“psychiatric” should be “psychotic”	/ wrong word
P195 Line 19 /	“Joe” should be “Jo”	/ spelling
P197 Line 18 /	“didn’t help” should be “did help”	/ wrong word

CALIFORNIA JURAT WITH AFFIANT STATEMENT

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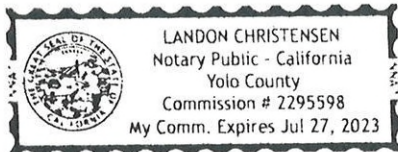
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(1) Ryan Gorton(and (2) _____),
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Federal Rules of Civil Procedure

Rule 30

(e) Review By the Witness; Changes.

(1) Review; Statement of Changes. On request by the deponent or a party before the deposition is completed, the deponent must be allowed 30 days after being notified by the officer that the transcript or recording is available in which:

(A) to review the transcript or recording; and

(B) if there are changes in form or substance, to sign a statement listing the changes and the reasons for making them.

(2) Changes Indicated in the Officer's Certificate. The officer must note in the certificate prescribed by Rule 30(f)(1) whether a review was requested and, if so, must attach any changes the deponent makes during the 30-day period.

DISCLAIMER: THE FOREGOING FEDERAL PROCEDURE RULES ARE PROVIDED FOR INFORMATIONAL PURPOSES ONLY.

THE ABOVE RULES ARE CURRENT AS OF APRIL 1, 2019. PLEASE REFER TO THE APPLICABLE FEDERAL RULES OF CIVIL PROCEDURE FOR UP-TO-DATE INFORMATION.

VERITEXT LEGAL SOLUTIONS
COMPANY CERTIFICATE AND DISCLOSURE STATEMENT

Veritext Legal Solutions represents that the foregoing transcript is a true, correct and complete transcript of the colloquies, questions and answers as submitted by the court reporter. Veritext Legal Solutions further represents that the attached exhibits, if any, are true, correct and complete documents as submitted by the court reporter and/or attorneys in relation to this deposition and that the documents were processed in accordance with our litigation support and production standards.

Veritext Legal Solutions is committed to maintaining the confidentiality of client and witness information, in accordance with the regulations promulgated under the Health Insurance Portability and Accountability Act (HIPAA), as amended with respect to protected health information and the Gramm-Leach-Bliley Act, as amended, with respect to Personally Identifiable Information (PII). Physical transcripts and exhibits are managed under strict facility and personnel access controls. Electronic files of documents are stored in encrypted form and are transmitted in an encrypted fashion to authenticated parties who are permitted to access the material. Our data is hosted in a Tier 4 SSAE 16 certified facility.

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